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| N 000 | Initial Comments<br><br>Based on the results of a survey for investigation of complaints #30998, #30952, #30950, #30891, #30886, #30751, #30734 and #30815, were substantiated and the facility was cited a Type "A" Penalty for failure of the facility administration to provide a system to ensure necessary care and services were provided; failure to ensure medications were obtained and administered as ordered, treatments and personal care were provided, laboratory tests were obtained and reported, nursing staff were trained and on duty in sufficient numbers to meet the needs of the residents, ensure an environment free of accident hazards and provide supervision to prevent accidents, to accurately and consistently assess resident's skin integrity and provide appropriate interventions to prevent and treat pressure sores, to provide a system to ensure residents were free from significant medication errors, to ensure the facility Quality Assurance Committee identified areas for improvement related to quality of care and develop plans of action; and to ensure the facility Medical Director coordinated medical care in the facility by ensuring residents received medications, laboratory services, pharmacy services as ordered by the physician. Complaint investigation #30769 was not substantiated.<br><br>The facility's failure placed resident # 5, #6, #7, #10, #11, #2, #16, #17, #18, #19, #20, #26, #28, #31, #32, #33, #34, #35, #36, #37, #38, #39, #42, #43, #44, #49, #50, #51, #52, #53, #55, #62, #70, #71, and #72 in an environment which was detrimental to their health, safety, and welfare. | N 000 | | |
| N 401 | 1200-8-6-.04(1) Administration<br><br>(1) The nursing home shall have a full-time (working at least 32 hours per week) | N 401 | | |

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| N 401 | Continued From page 1<br>administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility policy reviews, pharmacy record reviews, review of manufacturer's instructions, review of staffing schedules, observations, and interviews, the facility administration failed to provide a system to ensure necessary care and services; failed to provide supervision and an environment free of accident hazards; failed to ensure medications were obtained and administered as ordered, treatments and personal care were provided, laboratory tests were obtained and reported, and nursing staff were trained and on duty in sufficient numbers to meet the needs of the residents. The facility's failure placed all residents residing in the facility in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Interview with the Administrator on January 28, 2013, at 3:00 p.m., in the Administrator's Office confirmed the nurse competency/education had been "severely neglected for a long time in this | N 401 | | |

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| N 401 | Continued From page 2<br><br>facility." Continued interview confirmed the Administrator had not been involved in Nursing Services, Abuse Investigations, and/or education. Further interview at this time confirmed the Administrator had a Job Description on file at the Corporate Office and provided the surveyor a copy.<br><br>Interview with the Administrator on February 13, 2013, at 4:10 p.m., in the Administrator's Office, confirmed the Administrator had been aware of the high turnover in staffing, cycle of leadership turnover, "problem with medication transcriptions in mid November", and no monitoring of medication errors.<br><br>Review of Job Summary provided by the Administrator updated January 9, 2013, revealed " ...Job Summary: The primary purpose of the Nursing Home Administrator position is to oversee the day-to-day operation of the facility and to review organizational performance ...Job Duties & Responsibilities: Oversee the nursing services, social services programs, activity programs, food service programs and medical services are planned, implemented and evaluated to meet resident needs to maximize resident quality of life and quality of care ....Oversee that a pharmaceutical program is planned ...Oversee that residents receive care in a manner and in an environment that maintains or enhances their quality of life ...Develop, implement, and monitor recruitment, development, evaluation, and retention programs to provide quality resident care and services ...Maintain responsibility for an adequate number of appropriately trained professionals and auxiliary personnel being on duty at all times to meet the needs of the residents ...Oversee the planning, conducting, and scheduling of in-service training classes, | N 401 | | |

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| N 401 | Continued From page 3<br>on-the-job-training and orientation programs to assure that current material and programs are continuously provided ...Monitor competence of the work force ...Oversee that information management systems are in place to support facility operations ..." | N 401 | | |
| N 424 | 1200-8-6-.04(15) Administration<br><br>(15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, review of facility investigation, review of a weather report, review of a facility assignment sheet, review of facility policy, observation, interview, review of manufacturer's recommendations, review of an action plan, the facility failed to ensure adequate supervision and assistive devices were provided for eight residents (#39, #51, #53, #52, #49, #11, #38, #37) of seventy-nine residents reviewed. The facility's failure to provide an assessment and correctly apply a bed assist handle resident #39, #51, #53, and #52, failure to provide adequate supervision and staff to prevent an elopement for resident #49, and failure to provide supervision and assistive devices to prevent falls resulting in fractures for residents #11,#38, #37, placed resident #39, #51, #53, #52, #49, #11, #38, #37, in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Resident #39 was admitted to the facility on November 13, 2012, with diagnoses including | N 424 | | |

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| N 424 | Continued From page 4<br><br>Hematuria, Urinary Obstruction, Urinary Tract Infection, Alzheimer's Disease, Congestive Heart Failure, Anemia, Chronic Kidney Disease, Dysphagia, Retention of Urine, Atrial Fibrillation, Hypertension, and Peripheral Vascular Disease.<br><br>Medical record review revealed the resident was discharged to another nursing home on January 7, 2013.<br><br>Medical record review of a Nursing Assessment dated November 20, 2012, revealed the resident had short and long term memory loss, severely impaired cognitive skills, required extensive assistance of two persons for transfers, did not walk in the corridor, and a urinary catheter was used.<br><br>Medical record review of an electronic nursing note dated November 29, 2012, at 2:04 a.m., revealed "pt (patient) found on fl (floor) next to bed...the head caught in the rail, 4 people tried to pick (resident) up and unsuccessful, made pt comfortable and call np (Nurse Practitioner)...transfer out for eval (evaluation) and spoke w/ (with) daughter...and expl (explained) situation. v/s (vital signs) 160/88, 14, (respirations) 98.8, O2 sat (saturation) f/a (room air) 94...no visible signs of trauma to head, foley cath (catheter) over 1000 ml (milliliters) of large amount of blood tinged urine...pt. unable to make sense or tell me where...was. Pt. unable to stand on...own or w/4 people assistance, bowel large amount on bed and floor and pts hands and body. Pt monitored till ambulance arrived..."<br><br>Review of facility investigation dated November 29, 2012, completed by LPN #7, revealed "...doing rounds found pt on floor and...head caught between rails and floor. Pt. unable to | N 424 | | |

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| N 424 | Continued From page 5 | N 424 | | |

respond and head cold, unable to v/s (take vital signs) due to pts position, no visible signs of any trauma, foley cath to have over 1000 ml of large amount of blood in foley...no visible signs of trauma, pt unable to speak or mutter sounds...called for cnt (Certified Nursing Assistant/Technician) (CNA #10) and nurse (LPN #14) for assistance, unable to (pick) pt (up) by us called in (LPN #15) and (CNA #11) still unable to pick pt up, got pts head out of rails and made pt comfortable on floor till ambulance arrived..."

Medical record review of a Hospital Emergency Physician Record dated November 29, 2012, revealed "Pt found in NH (nursing home) with head b/t (between) rail and mattress...Head/EENT (eyes, ears, nose, throat)...no apparent trauma...airway intact..."

Medical record review of a hospital Discharge Summary dated December 13, 2012, revealed "Final Discharge Diagnoses: 1. Status post fall. 2. Possible concussion in demented patient. 3. Leukocytosis. 4. Recurrent Foley (urinary catheter) malfunction. Urinary tract infection...11. Dementia...On the morning of admission...was found at the nursing home with his head in between a rail and the mattress...had altered mental status...was brought to the emergency room where...was found to have leukocytosis...mental status was decreased from...baseline...was admitted for further evaluation and management...Ultimately, the decision was made for comfort care...returned to (nursing home) with comfort care orders..."

Telephone interview with LPN #7 on January 29, 2013, at 1:40 p.m., revealed LPN #7 had discovered resident #39 with the head between the mattress and the rail (assist bar), on the left

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| N 424 | Continued From page 6<br><br>side of the bed. LPN #7 stated the resident's head was "wedged between the mattress and the rail" (assist bar), and it took four staff members to remove the resident's head from between the mattress and the assist bar. Continued interview revealed the rail was positioned towards the head of the bed, and the rail was smaller than a ¼ side rail.<br><br>Telephone interview with LPN #7 on January 30, 2013, at 6:15 p.m., revealed when the LPN observed resident #39 with the head wedged between the mattress and the assist bar, the resident's head was caught between the mattress and the bar, and the forehead was inside the bar. Continued interview revealed the urinary catheter was stretched, and the resident's legs and torso were partially on the bed and partially dangling off the bed. Continued interview revealed LPN #7 and one of the CNAs were able to free the resident's head from between the mattress and the bar. Continued interview revealed the resident's head had been wedged tightly down into the mattress and the bar, the resident's head and face were cold, and there were no marks on the resident's head or face. Continued interview revealed LPN #7 was able to obtain assistance and staff members responded quickly in two to three minutes. Continued interview revealed the resident was found with the head between the mattress and the assist bar at approximately 1:00 a.m. on November 29, 2012, and LPN #7 had last seen the resident prior to the incident at approximately 9:00 or 9:30 p.m. LPN #7 stated "...was wedged so tight me and my staff couldn't get (the resident) up-there was a gap between the mattress and rail. I think...was trying to get out of bed on the left side and the mattress slid to the right...was confused and trying to get up." | N 424 | | |

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| N 424 | Continued From page 7<br><br>Telephone interview on January 30, 2013 at 1:30 p.m., with CNA #10 revealed the CNA was working the night of November 29, 2012, when LPN #7 came into the hallway and called for help. Continued interview revealed CNA #10 had not seen the resident's head wedged between the mattress and assist bar. Continued interview revealed the resident's head was on a pillow when CNA #10 saw the resident.<br><br>Telephone interview on January 30, 2013, at 2:30 p.m., with CNA #11 revealed the CNA remembered another staff member had summoned CNA #11 to assist with resident #39. Continued interview revealed the resident was on the right side and the resident's head was wedged under the bed, the resident's head was un-wedged and the resident was left on the floor.<br><br>Interview on January 30, 2013, at 7:10 a.m., with LPN #15, in the conference room, revealed the LPN remembered the resident was on the floor, was called to assist getting the resident off the floor, and the resident had been left on the floor due to a possible head injury. Continued interview revealed the assist bars had "give" in them, and were "flimsy." Continued interview revealed flimsy meant when force was applied, the bar could be pulled away from the bed frame. Continued interview revealed there could be a gap between the bar and the mattress and the resident could get an arm entangled between the mattress and the assist bar.<br><br>Interview on January 31, 2013. at 7:20 a.m.. with LPN #14, in the conference room, revealed the LPN remembered the night resident #39's head was wedged between the mattress and the assist bar. Continued interview revealed when LPN #14 had entered the resident's room the resident's | N 424 | | |

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| N 424 | Continued From page 8<br><br>back was facing LPN #14, the resident's knees were on the floor and the resident's head was between the mattress and the rail. Continued interview revealed the resident's bed was low to the floor, with a regular mattress, and it took approximately two minutes to disentangle the resident after LPN #14 entered the room and there were at least four staff members in the room at the same time.<br><br>Interview on January 29, 2013, at 1:50 p.m., in the conference room, with Quality Improvement Coordinator #1, revealed resident #39's head had been wedged between an assist bar and the mattress on November 29, 2012. Continued interview revealed employee statements related to the incident had been misplaced.<br><br>Interview on January 29, 2013, at 3:55 p.m., with Quality Improvement Coordinator #1 and the Director of Nursing (DON), in the conference room, revealed it was unknown how many residents had assist bars (bed assist handle) on the bed, it was unknown who applied the assist bar to resident #39's bed, it was unknown if anyone had checked to ensure the assist bar was correctly applied, and the resident had not been assessed for the use of the assist bar. Continued interview confirmed there was no interim care plan developed for the resident to address the assist bar.<br><br>Interview with the DON on January 30, 2013, in the conference room revealed the facility had no policy for the assist bars. Continued interview revealed residents with assist bars needed to be evaluated by therapy or nursing for the use of the assist bars, and did not know who applied the assist bars and did not know who to ask. Continued interview confirmed resident #39 had | N 424 | | |

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| N 424 | Continued From page 9<br>not been assessed for the use of the assist bar.<br><br>Interview on January 31, 2013, at 9:10 a.m., with Quality Improvement Coordinator (QIC) #1, revealed QIC #1 was present in the facility daily at the time of the incident on November 29, 2013, and had investigated the incident. Continued interview revealed QIC #1 went to resident #39's room on the morning of November 29, 2013, after the resident had been transferred to the hospital. Continued interview revealed the bed assist bar had been removed from the bed and was on the floor when the nurse entered the resident's room. Continued interview revealed it was QIC #1's understanding the resident's head was between the mattress and the curve of the assist bar. (The assist bar is a "L" shape with the bottom of the "L" sliding under the mattress). Continued interview revealed QIC #1 did not know who applied the assist bar. Continued interview revealed there was no system in place to determine the need for the assist bars and "maybe" therapy or communication between the staff was used. Continued interview revealed after resident #39 was found with the head between the mattress and the assist bar, the resident was sent to the hospital and maintenance was given directions to look at all assist bars to ensure safety. When asked what action the facility was taking now related to the use of the assist bars, QIC #1 responded "honestly nothing different..." Continued interview revealed QIC #1 "assumed the assist bar was not applied correctly" to resident #39's bed.<br><br>Review of the manufacturer's instructions for the "bed assist handle" revealed "installation instructions - This Bed Assist Handle is designed for use with most mattress and box spring type beds. 1. Remove contents from carton. 2. | N 424 | | |

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| N 424 | Continued From page 10<br><br>Remove mattress from bed. 3. Attach the hand brace...to the base support frame by depressing the brass lock pins and sliding the hand brace into the tubing...until the lock pins 'snap' through the positioning holes. 4. Place assembled base support frame on top of the box spring...5. Unbuckle the strap and lay flat. 6. Position the bed assist handle so that the space between the vertical handle bars and the other bedside device or bed board must be less than 2.26 inches (60mm) (millimeters), or larger than 9.25 inch (235 mm). 7. Place bed assist handle so that the strap is exposed on both sides of the bed...Place mattress on bed. 8. Buckle the strap and adjust by tightening the loose end of the strap...Warning This assist handle is intended for assisting in and out of bed only. DO NOT use for other purposes. Mattress must fit bed frame and assist handle snugly to prevent potential patient entrapment. Patient entrapment may cause injury or death!..."<br><br>Interview on January 31, 2013, at 9:35 a.m., with the Plant Operations Manager, in the conference room, revealed Plant Operations or the Central Supply Coordinator could apply assist bars to the beds in the facility. Continued interview revealed no special instructions were received on how to apply the assist bars. Continued interview revealed general maintenance practices were used to apply the assist bars and the Plant Operations Manager did not know who applied resident #39's assist bars.<br><br>Interview on January 31, 2013, at 9:40 a.m., with the Assistant Plant Operations Manager, in the conference room, revealed was unaware of the incident with resident #39 and the bed bar until a day or two ago. Continued interview revealed the assist bars strapped to the bed were not tight, and were shaky when mounted. Continued | N 424 | | |

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| N 424 | Continued From page 11<br>interview revealed the Assistant Plant Operations manager had tried to install one of the bed bars with straps and did not apply the assist bar because it was "shaky." Continued interview revealed the bed bars with straps were not real secure.<br><br>Interview on January 31, 2013, at 9:50 a.m., with the Central Supply Coordinator (CSC), in the conference room, revealed the CSC had ordered the Bed Assist Handles (bed bars) used in the facility. Continued interview revealed the CSC or maintenance applied the bed bar to the beds. Continued interview revealed the CSC did not know who had applied the bed bar to resident #39's bed or the date it was applied. Continued interview revealed the CSC was responsible to ensure the bed bar was applied correctly and confirmed had not followed-up to ensure the safety of resident #39's bed bar.<br><br>Interview on January 31, 2013, at 1:25 p.m., with the Plant Operations Manager, in the lobby, revealed an awareness of the incident with resident #39. Continued interview revealed after the incident the Plant Operations Manager was told to see if side assist bars were too long, and was not told to check for gaps between the mattress and the bars. Continued interview revealed there was no documentation of checking the assist bars for proper application.<br><br>Interview on January 31, 2013, at 1:50 p.m. with the Assistant Plant Operations Manager, in the lobby, revealed no knowledge of the incident with resident #39 until a day or two ago, and had received no special instructions related to the use of the assist bars.<br><br>Interview on January 31, 2013, at 10:05 a.m., with | N 424 | | |

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| N 424 | Continued From page 12<br><br>the Administrator, in the conference room, revealed the Administrator became aware of the incident with resident #39 on November 29, 2012, and confirmed no recommendations had been made to the facility staff related to the use of the assist bars.<br><br>Interview on January 30, 2013, at 10:45 a.m., with the Medical Director, in the conference room, revealed the therapy department made recommendations for the use of the assist bars.<br><br>Interview on January 30, 2013, at 3:30 p.m., with the Rehabilitation Manager, in the conference room, revealed therapy had not made a recommendation for resident #39 to use an assist bar.<br><br>Telephone interview on January 31, 2013, at 9:30 a.m., with the Medical Director, revealed the Medical Director had reviewed the incident when resident #39's head was wedged between the mattress and the assist bar. Continued interview revealed "it was a dangerous situation."<br><br>Resident #53 was admitted to the facility on October 11, 2010, and readmitted on January 19, 2013, with diagnoses including Late Effect Hemi-plegia Dominant Side Right, Dialysis, and Peripheral Vascular Disease.<br><br>Medical record review of a Nursing Assessment dated January 11, 2013, revealed was moderately impaired for daily decision making, required extensive assistance for Activities of Daily Living, and no side rails were used for this resident.<br><br>Medical record review of the Interdisciplinary Care Plan dated January 28, 2013, revealed | N 424 | | |

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| N 424 | Continued From page 13<br><br>"...Problem...Self Care Deficit/Impaired mobility...1/4 upper dble (double) side rails when in bed..."<br><br>Medical record review of a CNA (Certified Nurse Assistant) Assignment Card printed January 30, 2013, revealed "...Problem...Self Care Deficit/Impaired mobility...1/4 upper dble (double) side rails when in bed..."<br><br>Observation on January 29, 2013, at 4:30 p.m., revealed Resident #53 sitting in a wheelchair and an assist bar on the right side of the bed applied underneath the mattress and not attached to the bed.<br><br>Observation on January 30, 2013, at 7:15 a.m., in the resident's room revealed the resident lying in the bed asleep and no assist bar in place.<br><br>Observation on January 30, 2013, at 10:35 a.m., in the resident's room, revealed the resident lying in the bed and no assist bar in place.<br><br>Interview with resident #53 on January 30, 2013, at 10:35 a.m., in the resident's room, confirmed the resident had an assist bar and the "man down stairs" took it off.<br><br>Interview on January 30, 2013, at 3:05 p.m., in the Central Hallway, with the CSC, revealed the assist bar had been removed on the evening of January 29, 2013. Further interview at this time confirmed the CSC had not received any request to remove the assist bar and nursing had not been notified.<br><br>Interview on January 30, 2013, at 3:05 p.m., in the Central Hallway, with Registered Nurse (RN) #2, revealed no assessment had been completed | N 424 | | |

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| N 424 | Continued From page 14<br>on the assist bar until January 29, 2012.<br><br>Interview on January 31, 2013, at 1:30 p.m., in the front lobby, with RN #2, confirmed the facility had failed to complete an assessment for the use of the assist bar prior to placement for the resident's use.<br><br>Resident #51 was admitted to the facility on October 6, 2010, with diagnoses including Blood Coagulation Disorder, Hypertension, Cerebrovascular Disease, and Vascular Dementia with Delusion.<br><br>Medical record review of a Nursing Assessment dated November 2, 2012, revealed the resident was moderately impaired for cognitive skills, required extensive assistance of one person for bed mobility, and required extensive assistance of one person for transfers.<br><br>Medical record review revealed no assessment for the use of the assist bar.<br><br>Observation on January 30, 2013, at 7:20 a.m., revealed the resident lying on the bed with the assist bar elevated on the right side of the bed.<br><br>Interview on January 30, 2013, at 2:20 p.m., with CNA #1, in the hall, confirmed the resident uses the assist rail to assist in turning.<br><br>Interview on January 30, 2013, at 2:45 p.m., with LPN #6, in the conference room, confirmed no assessment had been completed for the use of the assist bar.<br><br>Resident #52 was admitted to the facility on December 21, 2012, with diagnoses including Atrial Fibrillation, Muscle Weakness, Cardiac | N 424 | | |

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| N 424 | Continued From page 15<br>Failure, History of Stroke, and Recent Pneumonia.<br><br>Medical record review of a Nursing Assessment dated December 1, 2012, revealed "...Bed mobility...extensive assistance of one..."<br><br>Observation of the resident on January 31, 2013, at 9:47 a.m., revealed the resident in bed with assist hand rail in place to the right side of the bed. Interview with the at this time revealed the resident stated "...roommate had hand rail prior to me and it was not sturdy enough my roommate because roommate was heavier than me...It would hold you (surveyor)..."<br><br>Interview with the Nursing Assessment Coordinator #3 on January 30, 2013, at 7:28 a.m., in the Assessment Coordinator's office, confirmed the hand rail was not assessed prior to implementation.<br><br>Resident #49 was admitted to the facility on June 4, 2012, with diagnoses including Senile Dementia, Depressive Disorder, Anxiety, Hypertension, and Urinary Tract Infection.<br><br>Medical record review of a Nursing Assessment dated August 1, 2012, revealed the resident had severely impaired cognitive skills and wandered one to three days of seven.<br><br>Medical record review of a Wandering Resident Assessment dated September 27, 2012, revealed the following: The resident was not always aware of surroundings; was restless during the day; was impulsive with movements or completing tasks; was not able to follow directions; did not always sleep through the night; was not always compliant with care; had a history of wandering; was exit | N 424 | | |

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| N 424 | Continued From page 16<br>seeking; and was at high risk for wandering/elopement.<br><br>Medical record review of the Care Plan reviewed by the Interdisciplinary Team on June 25, 2012, revealed "...potential for wandering about facility/elopement...(undated on June 16, 2012) Nurses...Address elimination needs, observe location, offer diversion...Nurse Aide...Observe location, Redirect restlessness into productive activity, offer diversion, offer and assist to activities, offer conversation..."<br><br>Medical record review of a Social Service notes dated December 12, 2012, revealed "Patient was found outside building 12-11-2012. Patient placed on 1 to 1. Social services had left message with and then spoke with daughter...on the afternoon on 12-11-2012 to discuss transfer to another facility that had a wander guard system or a locked unit...understood that the transfer was for...safety and agreed..."<br><br>Review of a facility investigation dated December 11, 2012, at approximately 3:45 a.m., revealed "pt (patient) has been hostile and aggravated tonight...has refused...medicines and would not lie down. Pt. was found outside by ambulance service a short distance from due west (West Due West is a street in front of facility)...had made...way up the hill trying to get something to eat. emt's (emergency medical technicians) were asked if pt said anything about...was outside...stated...was going to get something to eat...tried walking to the side entrance of the facility but it was too cold and too dark, so...turned around and headed up the hill. The cnt (certified nursing technician/assistant) on the unit was following behind pt up the hill to bring...back to the facility. The ambulance | N 424 | | |

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| N 424 | Continued From page 17<br>service drove the cnt and pt back to the facility. Pt has been assessed with no changes...was going to get something to eat..."<br><br>Review of a facility investigation and a statement prepared by the CNA, dated December 11, 2012, revealed "...At approximately 3:40 a.m., on 12/11/12, I...CNA was informed by a...EMT that one of our residents (resident #49) was seen walking up the hill towards Due West Ave. I was the only employee on the center wing at this time because the charge nurse...had just left for...break 10 minutes earlier. I immediately ran outside facility & (and) up hill (on foot) to redirect (resident #49) back into facility, we were both driven back down hill by the...EMTs. Upon entering the building I helped (resident #49) to...room & got the nearest charge nurse from East Hall...as the center wing nurse was still on...break at this time. Resident was not complaining of any pain or discomfort at this time."<br><br>Review of Weather Underground temperatures for Nashville, TN, revealed the temperature on Tuesday December 11, 2012, at 2:53 a.m., and 3:53 a.m., was 33.1 degrees F (Fahrenheit) with a wind chill of 26.9 degrees F.<br><br>Review of the 7:00 p.m. until 7:00 a.m., assignment sheet for December 10-11, 2012, revealed CNA #5 and LPN #18 were the only staff members assigned to the Center Wing where resident #49 resided at the time of the elopement on December 11, 2012.<br><br>Review of facility policy, Wandering/Elopement, revealed "It is the policy of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the | N 424 | | |

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| N 424 | Continued From page 18<br>risk of an elopement...Elopement occurs when a resident leaves the premises or a safe area without authorization..and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of...heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle...Before or upon admission every resident will be screened using the Wandering Resident Assessment...Residents found to be at moderate to high risk will be identified as residents having the potential to wander and who are at risk for elopement...Each resident having the potential to wander will have two (2) pictures taken, one a close up portrait of the residents face and a second full-length picture. These pictures will be placed in the Wandering Resident book along with a description of the resident. Photos should be updated at least annually. A copy of each identified resident's face sheet will also be included in this book. This will ensure that the facility staff is aware of residents who exhibit wandering behaviors. All new staff member(s) are oriented to the Wandering Resident book...If a resident is exhibiting wandering behavior that escalates and results in the resident exiting the facility or a secured area, the resident will be returned and 1:1 staff safety checks will be implemented until exit seeking behavior subsides. Then 30-minute safety checks will be implemented for four (4) hours, then 1-hour checks for (4) hours...If a resident wanders less frequnetly than daily, the episodes are documented in the medical record when they occur. The interventions and effectiveness of those interventions are also documented...Nurses document wandering behavior in the monthly summaries, comparing episodes, identifying triggers for wandering, and evaluating the effectiveness of interventions that were | N 424 | | |

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| N 424 | Continued From page 19<br>implemented...If a resident has wandered from the resident care unit or safe area or has eloped, and is missing, the procedure for a missing resident is initiated..."<br><br>Review of facility policy, Elopement Drill, revealed "It is the policy of this facility that the facility staff will provide drills for locating residents that have a potential to elope, on a quarterly basis..."<br><br>Interview on January 23, 2013, at 12:20 p.m., with Quality Improvement Coordinator (QIC) #1 in the hallway, revealed QIC #1 had worked on December 11, 2012, after the resident had eloped and upon learning of the elopement had investigated and put an Action Plan into effect. Continued interview revealed the side door was locked at the time the resident eloped from the building. Continued interview revealed the staff thought the resident had exited through the side door by pushing the code, and therefore the alarm did not sound.<br><br>Interview on February 7, 2013, at 4:05 p.m., with QIC #1 in the Director of Nursing office, confirmed there were no monthly summaries from October through December 12, 2012, to address the resident's wandering behaviors.<br><br>Interview on February 5, 2013, at 7:05 a.m., with CNA #5 in the conference room, revealed prior to December 11, 2012, approximately late October or early November, when arriving for work, resident #49 had approached CNA #5's car, in the parking lot and startled the CNA. Continued interview revealed CNA #5 had escorted the resident back into the facility, reported the incident to two nurses in the office and was unable to recall who the nurses were. Continued interview revealed no additional instructions for | N 424 | | |

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| N 424 | Continued From page 20<br><br>monitoring the resident were given at the time. Continued interview revealed on the night of December 11, 2012, CNA #5 was responsible for resident #49's care at the time the resident eloped from the facility. Continued interview revealed the ambulance service had transported another resident back to the facility and upon departure had noted a resident walking up the hill and alerted CNA #5. Continued interview revealed the resident was more than halfway up the hill, almost to the road. Continued interview revealed it was cold outside at the time the resident eloped from the building. Continued interview revealed CNA #5 and LPN #18 were the only staff members assigned to the Center Wing and LPN #18 was in their personal car on break at the time the resident eloped from the facility.<br><br>Interview on January 29, 2013, at 7:20 a.m., with LPN #18 in the conference room, revealed LPN #18 was responsible for resident #49's care on December 11, 2012, when the resident eloped from the facility. Continued interview revealed LPN #18 and CNA #5 were the only staff members assigned to the Center Wing with approximately 32-36 residents in their care. Continued interview revealed LPN #18 was on break outside the facility in personal car at the time the resident eloped from the facility. Continued interview revealed LPN #18 had seen the resident approximately 15-30 minutes prior to the resident exiting the building and the resident had been wandering about the facility with another resident. Continued interview revealed when the LPN interviewed the resident, the resident stated the door code numbers to exit through the side entrance had been entered by the resident and the resident had exited the building. Continued interview revealed LPN # 18 had told CNA #5 to observe the resident closely | N 424 | | |

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| N 424 | Continued From page 21<br>after the resident was returned to the facility. Continued interview confirmed there was not enough staff available to adequately supervise the residents on the Center Wing at the time the resident eloped from the facility.<br><br>Telephone interview on January 31, 2013, at 8:20 a.m., with LPN # 16 revealed was working on the East Wing on December 11, 2012, at the time resident #49 had eloped from the facility. Continued interview revealed CNA #5 had alerted the LPN after the resident was returned to the facility. Continued interview revealed the facility was short staffed at the time resident #49 exited the building.<br><br>Observation and interview with CNA #5 on February 6, 2012, at 7:05 a.m., revealed CNA #5 physically walked across the bridge of a stream in front of the facility and up the hill indicating where the resident was found on December 11, 2012. Continued observation revealed a Measure master by Rolatape was used to measure the distance from the facility front door to the spot the resident was found. Continued observation revealed the distance was 580 feet. Continued interview revealed the resident had been dressed in a black zip-up jacket, black pants, and black shoes. CNA #5 stated if the resident had made it to the street (West Due West) "wouldn't have stood a chance." Observation revealed West Due West was a four lane street.<br><br>Observation on February 14, 2013, at 10:15 a.m., revealed the Rolatape was used to measure the distance from where the resident was found on December 11, 2012, to the street, West Due West, and the distance was 349 feet.<br><br>Telephone interview on February 6, 2013, at 8:05 | N 424 | | |

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| N 424 | Continued From page 22<br>a.m., with the Operations Supervisor of the ambulance service revealed there was no documented record related to resident #49's elopement on December 11, 2012.<br><br>Interview on February 6, 2013, at 7:40 a.m., with LPN #17 in the conference room, revealed was aware resident #49 had exited the building prior to December 11, 2012 and the facility had given no additional instructions for monitoring the resident's safety.<br><br>Interview on February 7, 2013, at 4:15 p.m., with MDS Coordinator #1 in the MDS office revealed had heard the resident was found outside the building prior to December 11, 2012.<br><br>Interview on January 23, 2013, ay 3:15 p.m., with LPN #3, in the hallway revealed the LPN had cared for resident #49 and had heard about the resident exiting the building prior to December 11, 2012.<br><br>Interview on January 23, 2013, at 3:35 p.m., with CNA #4, in the hallway revealed the CNA had heard about the resident exiting the building prior to December 11, 2012.<br><br>Interview on February 5, 2013, at 10:45 a.m. with Restorative Nursing Assistant (RNA #1), in the conference room, revealed when the RNA reported to work on December 11, 2012, was told to do one on one supervision with resident #49 and to make sure the resident did not get out of bed. Continued interview revealed the RNA had provided one on one supervision to resident #49 for a few hours and was relieved by another RNA, who no longer works at the facility. Continued interview revealed RNA #1 did not know who provided the one on one supervision after 7:00 | N 424 | | |

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| N 424 | Continued From page 23<br>p.m., on December 11, 2012, until the resident was discharged.<br><br>Review of an Action Plan dated December 11, 2012, revealed "Elopement of resident...protection of resident-Resident put on one on one at 8:30 a.m. Facility looking for secure facility for resident. New elopement assessment completed. Resident care plan updated to reflect one on one, diversional activities (busy box) provided by activities, and HS (at bedtime) snack of whole sandwich and juice. (resident stated...left to find food). Doors with key pads will have codes changed and stickers removed that have codes on them. In-service started on missing resident procedure. Missing resident drill. Social services to make sure that all elopement books at all stations are up to date and have current pictures in them..."<br><br>Interview with QIC #1 on February 5, 2013, at 10:30 a.m., in the DON office revealed resident #49 was placed on every fifteen minute checks after the elopement on December 11, 2012, until 8:30 a.m., when the resident was provided one on one supervision until the resident was discharged to another facility on December 12, 2012. Continued interview revealed there was no documentation of the every fifteen minute checks or the one on one supervision.<br><br>Interview on February 6, 2013, at 4:00 p.m., with the Administrator in the hallway confirmed the last Missing Resident Drill conducted at the facility was in July 2011.<br><br>Interview on February 6, 2013, at 1:00 p.m., with Social Worker (SW #1), in the social service office, confirmed two of the four elopement books did not include a picture and information form for | N 424 | | |

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| N 424 | Continued From page 24<br>one of the residents identified at risk for wandering and elopement.<br><br>Resident #11 was admitted to the facility on September 14, 2012, with diagnoses of End Stage Renal Disease, Type 2 Diabetes, Cirrhosis, and Hepatitis C.<br><br>Medical record review of a Nursing Assessment dated October 8, 2012, revealed the resident required extensive assistance of one person for locomotion on nursing unit and total dependence for location off nursing unit.<br><br>Medical record review of a Nursing Progress Note dated October 13, 2012, revealed the resident was found lying face down uninjured on the floor and unable to explain what had happened. Continued medical record review of a Nurse's Progress Note dated October 15, 2012, revealed the resident was found sitting on the floor in the lounge area next to the time clock and had no injuries. Review of a CNA Assignment Card dated October 16, 2012, revealed "...Keep (resident) close to nursing station where (resident) can be observed more close... Place in wheelchair..."<br><br>Medical record review of a Nurse's Progress Note dated October 26, 2012 revealed "...at this time notified...patient laying on floor behind (resident's) door...Upon investigation patient complained to neck pain, right leg and arm pain...received order to transfer to ER (emergency room).<br><br>Interview with the CNA #15 on January 29, 2013, at 1:32 p.m., revealed the resident was in bed at the time of the fall. Continued interview with CNA revealed the resident was a dialysis patient and tended to space out when ammonia levels got | N 424 | | |

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| N 424 | Continued From page 25<br>high.<br><br>Interview on January 30, 2013, at 7:57 a.m., with the DON and the Assistant Director of Nursing (ADON) in the ADON office confirmed the October 13, 2012, and October 15, 2012, fall interventions to keep resident close to nursing station when up in wheelchair was not implemented until October 16, 2012, after the fall in which the resident was found sitting on the floor by the time clock. Continued interview confirmed there was no investigation completed at the time of the fall from bed on October 26, 2012, in which the resident was sent to the hospital with a Right Intertrochanteric Fracture requiring surgical intervention. Medical record review revealed the resident was admitted back to the facility on October 30, 2012.<br><br>Medcial record review revealed the resident had another fall on November 10, 2012, with no injury. Interview with the DON and the ADON in the ADON office on January 30, 2013, at 7:57 a.m., confirmed no new interventions had been put in place prior to the November 10, 2012 fall.<br><br>Medical record review of a Progress Note dated February 4, 2013, at 8:26 a.m., revealed "...Resident found on floor laying on rt (right) side...Notified...EMS (emergency medical services)...resident complains of pain on right hip and leg..." Continued medical record review of a hospital thoracic spine x-ray dated February 4, 2013, revealed "...Marked compression fracture approximately T8 (thoracic eight), with mild compression fractures at approximately T6 and T10 levels..."<br><br>Interview with the DON in the facility conference room on February 6, 2013, at 9:16 a.m., | N 424 | | |

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| N 424 | Continued From page 26<br><br>confirmed no new interventions were in place after the October 26, 2012, fall with fracture or the fall that occurred November 10, 2012. continued interview confirmed the facility had failed to provide supervison or assistive devices to prevent further falls and resulted in a fall with fractures on February 4, 2013.<br><br>Resident #38 was admitted to the facility on December 21, 2012, with diagnosis including Severe Sepsis, Urinary Tract Infection, Atrial Fibrillation, and Senile Dementia.<br><br>Medical record review of a Nurse's Progress Note dated January 3, 2013, at 12:00 p.m., revealed "...Late Entry for 01/03/2013. Resident weak and lethargic. Balance unsteady. Confusion noted. Blood pressure taken after being noted on the floor and 70/43...order obtained to send patient to ER..."<br><br>Medical record review of a Nurse's Progress Note dated January 6, 2013, at 7:05 p.m., revealed "...Mobile X-Ray here to see patient at this time, awaiting results..." Continued review of the Nurse's Progress Note at 9:24 p.m., revealed "...Results called to NP (nurse practitioner), new orders to put in walking boot for 3-4 weeks..."<br><br>Medical record review of a Right Foot X-Ray report dated January 6, 2013, revealed "...Transverse fracture base of the third metatarsal..."<br><br>Interview on February 7, 2013, at 7:05 a.m., with LPN #15, in the facility lobby, confirmed the resident family had stated the resident was having pain when ambulating and had three falls at the facility prior to going out to the hospital. Continued interview confirmed the LPN received | N 424 | | |

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| N 424 | Continued From page 27<br><br>an order from the NP to obtain the X-Ray on January 6, 2013. Continued interview confirmed an investigation was not completed on January 6, 2013, when the fracture was discovered.<br><br>Interview on February 7, 2013, at 7:38 a.m., with LPN #22, by telephone confirmed the resident had three falls on January 3, 2013, and the LPN had failed to complete a fall investigation at the time the falls occurred until January 7, 2013, when returned to work and after the resident was diagnosed with the fracture.<br><br>Interview with the DON in the DON office on February 8, 2013, at 10:53 a.m., confirmed the facility had failed to complete an investigation of the falls at the time the falls occurred on January 3, 2013, and failed to complete an investigation of the newly discovered fracture on January 6, 2013.<br><br>Resident #37 was admitted to the facility on March 22, 2012, with diagnosis including Senile Dementia, Schizoaffective Disorder, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus.<br><br>Medical record review of a facility fall investigation report dated October 31, 2012, revealed "...Resident was observed in floor in the hall in front of...wheelchair...lying facedown...states...doesn't know what happened..." Continued review of the facility investigation revealed "...Level of pain (left blank)...mental status (left blank)...environmental factors (left blank)...predisposing physiological factors (left blank)...predisposing situation factors (left blank)..."<br><br>Interview and facility investigation review with the DON in the DON office on February 5, 2013, at | N 424 | | |

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| N 424 | Continued From page 28<br>7:28 a.m., confirmed the facility investigation of the October 31, 2012, fall was uncompleted. | N 424 | | |
| N 601 | 1200-8-6-.06(1)(a) Basic Services<br><br>(1) Performance Improvement.<br><br>(a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility policy reviews, pharmacy record reviews, review of manufacturer's instructions, review of staffing schedules, observations, and interviews, the facility Quality Assurance Committee failed to identify areas for improvement related to quality of care and develop plans of action to ensure medications were obtained and administered as ordered, treatments and personal care were provided, laboratory tests were obtained and reported, and nursing staff were trained and on duty in sufficient numbers to meet the needs of the residents. The facility's failure placed all residents residing in the facility in an environment which was detrimental to their health, safety and welfare.<br><br>The findings included:<br><br>Interview on February 13, 2013, at 4:10 p.m., with the Administrator, in the Administrator's office, revealed the Administrator was the chairman of the Quality Assurance (QA) Committee. Continued interview revealed the QA committee the had not identified a problem with the bed assist handle/rail because the Administrator did | N 601 | | |

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| N 601 | Continued From page 29<br>not believe resident #39's head was wedged between the mattress and the bed assist handle/rail. Continued interview confirmed the Quality Assurance Committee had not identified problems with medication availability, including pain medications, and laboratory services not completed timely, or a problem with physician notification of laboratory results. Continued interview revealed the facility had staffing issues, and had eight Administrators and ten Directors of Nursing in less than two years, and currently had six open nursing positions. Continued interview revealed there were no checks for staff competency available. Continued interview revealed Quality Assurance meetings were held monthly. | N 601 | | |
| N 613 | 1200-8-6-.06(2)(d)1. Basic Services<br><br>(2) Physician Services.<br><br>(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:<br><br>1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care;<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility policy review, review of pharmacy records, review of controlled substance records, review of facility documentation, review of staffing schedules, interviews and observations, the facility Medical Director failed to coordinated medical care in the facility by ensuring residents received medications, laboratory services, pharmacy | N 613 | | |

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| N 613 | Continued From page 30<br><br>services as ordered by the physician, and failed to ensure residents received treatment and care, were supervised to prevent accidents and nursing sttaff were trained and on duty in sufficient numbers to meet the needs of the residents. The Medical Director's failure placed all residents residing in the facility in an environment which was detrimental to their health, safety and welfare.<br><br>Interview on February 13, 2013, at 1:00 p.m., with the Medical Director, in the Admission office, confirmed the Medical Director had been aware of residents not receiving pain medication and had told the facility to work better with the hospital to get the script and to work better with the backup pharmacy. Continued interview confirmed the Medical Director had talked to the Administrator and the Vice President of Clinical Services about the problems of residents not getting medications. Continued interview confirmed "know the system was broken" for obtaining needed medications, and confirmed my role is to say we have to get this fixed, not my role to micromanage.<br><br>Interview on February 13, 2013 at 1:45 p.m., with the Medical Director in the Admissions office revealed the Medical Director has twelve other buildings (nursing homes) that are visited every month. Interview revealed the Medical Director signs off on Medication Administration Records, looks at dietary, reviews falls and investigations, and reviews documentation on alarms on beds and chairs. The Medical Director stated "No way could read all signing." | N 613 | | |
| N 669 | 1200-8-6-.06(4)(c)4. Basic Services<br><br>(4) Nursing Services. | N 669 | | |

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| N 669 | Continued From page 31<br><br>(c) The Director of Nursing shall have the following responsibilities:<br><br>4. Notify the resident ' s physician when medically indicated.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, review of facility policy, observation, and interview, the facility failed to notify the physician of laboratory results, unavailable medications, medications not administered, and changes in condition for thirteen residents (#5, #6, #2, #35, #18, #28, #19, #7, #17, #37, #38, #42, #43) of seventy-nine residents reviewed.<br><br>The facility's failure to notify the physician of laboratory results for four residents (#5, #19, #17, #38), failure to notify the physician of a delay in administration of pain medications for two residents (#6, #43), failure to notify the physician of a newly developed pressure ulcer for resident #2, failure to notify the physician of psychiatric recommendations for one resident #35, failure to notify the physician for admission orders for two newly admitted resident's (#18, #43), failure to notify the physician of antibiotics not administered as ordered for three residents (#28, #7, #42), failure to notify the physician of elevated blood sugars (twenty-two times) for one resident #37, placed resident #5, #6, #2, #35, #18, #28, #19, #7, #17, #37, #38, #42, #43 in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included: | N 669 | | |

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| N 669 | Continued From page 32<br><br>Resident #5 was admitted on May 31, 2012, with diagnoses including Urinary Tract Infection, Bacteremia, Chronic Pain, and Pressure Ulcer.<br><br>Medical record review of a Nursing Assessment dated December 10, 2012, revealed the resident had been cognitively intact for daily decision making, and required extensive assistance for all Activities of Daily Living (ADL's).<br><br>Medical record review of a Urinalysis obtained on November 15, 2012, revealed "...this was not addressed..." (hand written no date)<br><br>Medical record review of a Physician Progress Note dated December 7, 2012, revealed "...The patient is being seen today for positive UA (urinalysis) and culture and sensitivity (C&S) from the middle of November, however was never addressed..."<br><br>Interview with the Medical Director (MD) on February 13, 2013, at 1:30 p.m., in the Admission Office, revealed the MD does not remember being notified of the Urinalysis results obtained on November 15, 2012. Further interview at this time confirmed the facility failed to notify the MD of the urinalysis results obtained on November 15, 2012.<br><br>Resident #6 was admitted to the facility on October 2, 2012, with diagnoses including Legally Blind, Healing Sacral Decubiti, Pain, Dysphagia, and Urinary Tract Infection.<br><br>Medical record review of a Nursing Assessment dated October 9, 2012, revealed the resident was cognitively intact, experienced limited vision, required extensive assistant with all ADL's, experienced pain frequently, feeding tube for | N 669 | | |

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| N 669 | Continued From page 33<br>nutrition, at risk of developing pressure ulcers, and oxygen had been used while a resident in the facility.<br><br>Medical record review of the Interdisciplinary Care Plan dated October 16, 2012, revealed "...Problem...comfort...administer pain meds..."<br><br>Medical record review of the October 1, 2012 through January 31, 2013, Order summary Report revealed "...Hydrocodone/Acetaminophen Tablet (Lortab) 7.5 - 325 mg (milligram)...Pain Give 2 tablets per tube 1 (every) 4 hr (hour) prn (as needed)...Start date 10/02/2012..."<br><br>Medical record review of a Nurse's Progress Note dated October 31, 2012, at 12:53 a.m., revealed "...note pt (patient) did not receive...prn meds (medications) at hs (hour of sleep) not available..."<br><br>Medical record review of a Nurse's Progress Note dated November 2, 2012, at 12:31 a.m., revealed "...pts pain med lortab are not available in Med Select (electronic secured medication cabinet) sent note to pharmacy..."<br><br>Medical record review of a Controlled Substance Record for Hydrocodone/APAP 7.5-325 dated November 1, 2012, (unknown delivery date) revealed the first dose given was on November 2, 2012, at 8:00 a.m.<br><br>Review of facility policy, Pain Management, dated revised 2010, revealed "...Purpose...to provide compassion...identify residents who has pain symptoms...through the appropriate pain management techniques...manage or prevent pain..." Pain" is an unpleasant sensory and emotional experience..." | N 669 | | |

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| N 669 | Continued From page 34<br><br>Review of facility policy C. Change in Condition Notification of Resident's Attending Physician, Family and Facility Associates of Change of Condition, dared revised 2010, revealed "...Policy It is the policy of this facility for communication of appropriate information relative to the resident's change of condition to the resident's attending physician, legal representative or responsible party and appropriate facility associates...Procedure...1. A resident's physician...must be notified of a change in the resident's condition within a time frame that is considered reasonable appropriate...4. Situations in which a physician...should be notified immediately of a change in a resident's condition include, but not limited to: Onset of any acute condition...any accident/incident with suspected or actual injury...Grossly abnormal vital signs...Critical laboratory signs...Medication errors..."<br><br>Interview with Licensed Practical Nurse (LPN) #7 on January 29, 2013, at 7:00 p.m., by telephone revealed the resident requested pain medication on October 31, 2012, and November 2, 2012, the Hydrocodone/APAP (lortab) was not available and the physician was not notified to obtain an alternative pain medication.<br><br>Interview with the Director of Nursing (DON) on January 30, 2013, at 1:20 p.m., in the DON office, confirmed the prescribed dose of Hydrocodone/APAP 7.5-325 was not available for administration from October 31, 2012, at 12:53 a.m. until November 2, 2012, at 8:00 a.m., (fifty-five hours) and the facility had failed to notify the physician of the resident's uncontrolled pain.<br><br>Resident #2 was admitted to the facility on June | N 669 | | |

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| N 669 | Continued From page 35<br><br>11, 2012, and readmitted to the facility on August 22, 2012, with diagnoses including Decubitus Ulcer, Peripheral Vascular Disease, Anxiety, and Dementia.<br><br>Medical record review of a Nursing Assessment dated January 13, 2013, revealed the resident was cognitively intact, required extensive assistance with all ADL's, always incontinent of urine, occasionally incontinent of bowel and one stage IV pressure ulcer.<br><br>Medical record review of a Nurse Progress Note dated October 8, 2012, at 3:04 p.m., revealed "...assessment of bilateral heels performed by wound care team...prep applied to heels and inflatable boots applied..."<br><br>Medical record review of a Weekly Summary dated October 9, 2012, revealed "...Site...right heel...Type...pressure...length...1.8...Width...3.7... Depth...0...Stage...Suspected Deep Tissue Injury...Site...left heel...Type...Pressure...Length...1.4...Width...0.8.. .Depth...0...Stage...Suspected Deep Tissue Injury..."<br><br>Medical record review revealed no documentation the Physician had been notified related to the deep tissue injuries until December 8, 2013.<br><br>Medical record review revealed no order was obtained for treatment to the heels until December 17, 2012.<br><br>Medical record review of the January 2012 Order Summary Report revealed "...Assess bilateral heels daily and float heels...apply hydrocolloid dressing to heels...every day shift..start date December 17, 2012." | N 669 | | |

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| N 669 | Continued From page 36<br><br>Interview with Registered Nurse (RN #1) (Wound Care Nurse) on January 28, 2013, at 10:30 a.m., in the Central Nurse's Station, confirmed the facility failed to notify the Physician of a Deep Tissue Injury on October 9, 2012, and no order had been obtained until December 8, 2012. (no order obtained continued skin prep)<br><br>Resident #35 was admitted to the facility on August 31, 2012, with diagnoses including Pathologic Fracture of Vertebrae, Major Depressive Disorder, Clostridium Difficile (C-Diff), and Urinary Tract Infection.<br><br>Medical record review of a Psychiatric Discharge Summary dated August 31, 2012, revealed "...History of present illness and admission mental status examination: history of Major Depressive Disorder, who presented on transfer from emergency department where...claimed...wished to be dead...Hospital Course:...endorsed a passive death wish...suicide precautions...Discharge Mental Examination:...denied passive death wish, suicidal ideations, homicidal ideations and plans...Follow up the physician at (named facility) will provide for the patients physical and psychiatric needs..."<br><br>Medical record review of a Nursing Assessment dated October 28, 2012, revealed the resident is cognitively intact, expressed feeling down, depressed, or hopeless several days, pain frequently, and received an antidepressant.<br><br>Medical record review of the Interdisciplinary Care Plan last updated January 15, 2013, revealed "...Problem Psychotropic Med Use...HX (history) of depression...request psychiatric | N 669 | | |

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| N 669 | Continued From page 37<br>consult..."<br><br>Medical record review of a Nurse's Progress Note dated January 5, 2013, revealed "...Pt (patient) is very confused this shift...talking about...death and dying..."<br><br>Medical record review of a New Resident Assessment Psychiatric dated January 31, 2013, revealed "...Depressed Mood...Social Isolation...Bipolar...Target Behavior/Symptoms: Withdrawn...Negative Statements...Recommendations: EKG (electrocardiogram)...have physician review...consider change of antidepressants for increased S/S (signs and symptoms) behavior symptoms.<br><br>Medical record review of a Physician's Telephone Order dated January 31, 2013, revealed "...EKG..."<br><br>Medical record review on February 13, 2013, revealed the psychiatric recommendations had not been followed. (thirteen days)<br><br>Observation and interview with resident #35, on January 29, 2013, at 10:50 a.m., in the east wing shower room on East Wing, revealed the resident dressed sitting in a wheel chair, and resident expressed was always depressed, no thoughts if suicide, and would like to talk to someone about the depression.<br><br>Interview with the Administrator on January 29, 2013, at 10:00 a.m., in the Administrator's office, revealed unaware resident #35 had expressed suicide ideations or expressed a death wish.<br><br>Medical record review of a Physician's Telephone | N 669 | | |

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| N 669 | Continued From page 38<br><br>Order dated January 29, 2013, revealed "...Patient to be seen by Psych (psychiatric) services for dx: (diagnosis) of Major Depressive Disorder..."<br><br>Interview with the Physician on February 15, 2013, at 7:15 p.m., by telephone, revealed the Physician had not been aware of the referral or recommendations for resident #35.<br><br>Resident #18 was admitted to the facility on November 10, 2012, with diagnoses including severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Senile Dementia, Esophageal Reflux, and Gastrostomy.<br><br>Review of the discharge medication list from the discharging hospital dated November 10, 2012, revealed "...CONTINUE taking these medications: Acetaminophen q 4 hr PRN (every 4 hours as needed), Albuterol Sulfate 1 puff every 4 hours as needed, Aspirin EC (enteric coated) 81 mg (milligrams) oral daily, Escitalopram Oxalate (Lexapro) 10 mg oral twice daily, Fluconazole 100 mg per tube daily x (times) 7 days, Metoprolol Succinate (Toprol) 50 mg oral bedtime, Mirtazapine (Remeron) 15 mg oral bedtime, Multivitamins, Thera w (with)-Minerals 1 tab oral daily, Pantoprazole sodium 40 mg oral or per tube daily, Quetiapine Fumarate (Seroquel) 12.5 mg oral twice daily, Quetiapine Fumarate 25 mg oral bedtime, Rivastigmine (Exelon) 9.5 mg transdermal patch daily, Valsartan (Diovan) 160 mg oral daily..." Further review revealed "STOP taking these medications...Hydroclorothiazide 25 mg oral daily, Potassium Chloride 40 meq (milliequivelant) oral daily..."<br><br>Review of facility policy, Centralized Admissions, revealed "...Procedure: Clinical Review... 6. The | N 669 | | |

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| N 669 | Continued From page 39<br><br>Registered Nurse Team Leader (RNTL) will review any orders that come with the resident from the hospital against the orders in PCC/ECS (computer systems) and make any changes that are needed. 7. The RNTL will print out orders from PCC/ECS and flag them for the MD (physician) to review and sign...."<br><br>Review of facility policy, Admission Process to Unit, with revision date (Rev.) 2010, revealed "...Procedure 9. Review transferring facility's recommendations and notify the attending physician to approve or change the recommendations to the admission orders and obtain additional orders if required...11. Enter the admitting physician orders in the electronic medical record...12. Process medications and other orders..."<br><br>Medical record review revealed there were no Physician Orders signed by the facility Physician on admission on November 10, 2012.<br><br>Interview with LPN #20, on January 22, 2012, at 2:00 p.m., at the 300 nursing station, confirmed LPN #20 was the admission nurse for resident #18 on November 10, 2012. Further interview confirmed the admission orders were not verified by the facility Physician on November 10, 2012. Further interview with LPN #20 on January 24, 2013, at 7:30 a.m., at the 300 hall nurses station, revealed resident #18 was a last minute admission close to the end of the shift.<br><br>Interview on January 22, 2013, at 1:10 p.m., in the conference room, with the Licensed Practical Nurse (LPN) #23, confirmed the nurse admitting the resident was to verify the discharge orders with the (facility) Physician and print the admission orders for the Physician to sign. | N 669 | | |

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| N 669 | Continued From page 40<br><br>Interview with Corporate Quality Improvement Coordinator (CQIC #1) on January 22, 2013, at 2:53 p.m., in the conference room, confirmed the facility failed to verify the hospital discharge medications with the facility Physician upon admission to the facility.<br><br>Resident #28 was admitted to the facility on June 12, 2012, with diagnoses including Atrial Fibrillation, Hypertension, Congestive Heart Failure, Diabetes Mellitus Type 1, Vascular Dementia, Peripheral Vascular Disease, and Atherosleroic Type Vessel Native/Graft.<br><br>Medical record review of a Physician telephone order dated October 19, 2012, revealed "Ergocalciferol 50,000 IU (International Unit) - 1 Q (every) Friday for 8 weeks (through Dec 14th) then once monthly until April 19th."<br><br>Medical record review of the January 2013 Order Summary Report revealed Ergocalciferol capsule 50,000 unit oral (by mouth) once daily start and end date January 18, 2013.<br><br>Review of the January 2013 electronic Medication Administration Record (eMAR) revealed on January 18, 2013, Ergocalciferol had initials and the number 9. Further review of the eMAR code information on the eMAR page revealed 9 was "other/See Nurses Notes."<br><br>Medical record review of the Nurse's Progress Note dated January 18, 2013, at 10:57 revealed "Type eMar -Medication Administration Note...Med (Medication) not found on cart. Will access from central supply and administer..."<br><br>Observation on January 30, 2013, at 3:15 p.m., | N 669 | | |

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| N 669 | Continued From page 41<br><br>with the CQIC #1 present, of the medication cart on the East wing back hall revealed a box labeled for resident #28 containing ten Vitamin D 1.25 milligrams (50,000) unit capsules.<br><br>Interview by telephone with Pharmacist #3, on January 30, 2013, confirmed Ergocalciferol was Vitamin D 1.25 milligrams (50,000).<br><br>Interview by telephone with LPN #1, on February 5, 2013, at 1:15 p.m., revealed "...I never seen this medication before and searched (medication) cart and talked with (LPN #21)...we looked up medication and found out Ergocalciferol was Vitamin D 2. We can't call pharmacy for an over-the-counter medication so went to (named staff member) Central Supply to see if had D 2. I saw D 3 in (medication) cart but I didn't want to give the wrong thing so I did not administer medication. I don't recall if the physician or the nurse practitioner was notified ...it would have been my responsibility to notify the physician or nurse practitioner..."<br><br>Interview with Nurse Practitioner (GNP #3) on February 6, 2013, at 10:30 a.m., in the conference room, confirmed "...okay to use Vitamin D 1.25 milligrams...for Ergocalciferol..."<br><br>Interview with CQIC #1, on February 7, 2013, at 4:00 p.m., in the DON's office, confirmed the Ergocalciferol was available on January 18, 2013, and the Nurse had failed to notify the Physician the Ergocalciferol had not been administered on January 18, 2013.<br><br>Resident #19 was admitted to the facility on November 9, 2012, with diagnoses including Cerebrovascular Disease, Gillian-Barre syndrome, Coronary Artery Disease, | N 669 | | |

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| N 669 | Continued From page 42<br><br>Hypertension, Dementia, Osteoporosis, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Acute on Chronic Renal Failure.<br><br>Medical record review of a Physician/GNP's order dated November 13, 2012, revealed a USA with a C&S was to be performed.<br><br>Medical record review of a laboratory report, obtained by the facility on November 14, 2012, with results received by the facility on November 18, 2012, revealed "...urine culture results...mixed gram positive bacteria identification and sensitivities not routinely performed..." Continued review of the laboratory report revealed an undated order to repeat the USA with C&S secondary to contaminated specimen.<br><br>Medical record review of a GNP's order dated November 24, 2012, revealed an order for Nitrification (anti-infective) 50 mg (milligrams) every twelve hours for seven days.<br><br>Medical record review of a positive USA C&S report collected on November 23, 2012, and received by the facility on November 25, 2012, revealed the causative organisms were Protest Amiability and Group B Beta Step. Continued review of the report revealed the Group B Beta Step was universally susceptible to penicillin, and the Protest Amiability was resistant to the Nitrification. Continued review of the report revealed the report was undated when initialed by a GNP.<br><br>Medical record review of the November and December 2012 Mars revealed the resident received Nitrification 50 mg by mouth twice daily November 25, 2012 through December 2, 2012. | N 669 | | |

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| N 669 | Continued From page 43<br><br>Observation on January 22, 2013, at 1:10 p.m., revealed the resident seated in a wheelchair, at the bedside, eating lunch.<br><br>Interview on January 22, 2013, at 11:00 a.m., with GNP #1 at the nursing station, revealed the Nitrification ordered on November 24, 2012, was ordered empirically to treat the resident's urinary tract infection (UT), and confirmed the facility had not notified the GNP or Physician of the results of the USA C&S collected on November 23, 2012, and results received by the facility on November 25, 2012, indicating the causative organism, Protest Amiability was resistant to the Nitrification. Continued interview confirmed the resident received the Nitrification unnecessarily November 26, 2012 through December 2, 2012.<br><br>Interview on January 23, 2013, at 7:30 a.m., with the DON, in the DON's office, confirmed the repeat positive USA with C&S obtained on November 23, 2012, and received by the facility on November 25, 2012, indicated the causative organism was Protest Amiability and was resistant to the Nitrification, and confirmed the facility staff did not notify the GNP/Physician the organism was resistant to the ordered medication.<br><br>Resident #7 was admitted to the facility on November 5, 2012, at 3:00 p.m., with diagnoses including Cerebrovascular Accident with Left Empress, Obstructive Chronic Bronchitis, Chronic Respiratory Failure, Epilepsy, Hypertension, Senile Dementia, and Dysphasia.<br><br>Review of the Edit Census Entry revealed the resident was admitted to the facility on November 5, 2012, at 3:00 p.m., and discharged home on November 6, 2012, at 4:00 p.m. | N 669 | | |

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| N 669 | Continued From page 44<br><br>Medical record review of resident #7's admission orders revealed the resident was to receive the following medications: Enrapturing (anticoagulant) 40 mg. (milligrams) subcutaneous every 24 hours; citalopram (antidepressant) 40 mg. daily; clopidogrel (platelet medication) 75 mg. daily; losartan potassium (antihypertensive) 25 mg. daily; aspirin 81 mg. daily; bupropion SR (antidepressant with sustained release) 150 mg. twice daily; phenytoin sodium extended (anticonvulsant) 300 mg. daily; and pantoprazole sodium (anti-ulcer) 40 mg. daily.<br><br>Medical record review of a Nursing Note dated November 5, 2012, at 9:44 p.m., revealed "hour of Administration note pts (patients) meds (medications) not in or medselect."<br><br>Medical record review of the November 5 and 6, 2012, MAR revealed no documentation the resident received the medications as ordered.<br><br>Interview by telephone interview on January 23, 2013, at 9:35 a.m., with Pharmacist #1 revealed the pharmacy never received any orders from the facility for the resident's medications.<br><br>Interview on January 23, 2013, at 9:50 a.m., with the DON, in the conference room, confirmed the resident's medications were not administered as ordered, and the Physician was not notified the medications were not administered as ordered.<br><br>Resident #17 was admitted to the facility on August 5, 2009, with diagnoses including Diabetes Mellitus and End Stage Renal Disease.<br><br>Medical record review of a Physician's telephone order dated January 8, 2013, revealed "...Stool | N 669 | | |

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| N 669 | Continued From page 45<br>culture for C. Diff (clostridium difficile)..."<br><br>Interview with LPN #23, at the 400 hall nurse's desk, on January 23, 2013, at 2:48 p.m., revealed no documentation the stool specimen was obtained.<br><br>Interview with the DON, in the DON's office on February 5, 2013, confirmed the Physician was not notified of the stool culture not completed.<br><br>Resident #37 was admitted to the facility on March 22, 2012, with diagnoses including Senile Dementia, Schizoaffective Disorder, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus.<br><br>Medical record review of an Order Summary Report revealed an order dated November 14, 2012, "...call MD (medical doctor) for blood sugar greater than 350..." Medical record review of the resident's Blood Sugar Summary from November 14, 2012, till January 3, 2013, revealed the resident's blood sugar to be greater than 350 twenty-two times.<br><br>Medical record review of Nurse's Progress Notes dated November 14, 2012, through January 3, 2013, revealed no documentation the MD notified of the blood sugars over 350.<br><br>Interview with the CQIC #1 on February 7, 2013, at 8:21 a.m., confirmed there was no documentation the MD was notified of the blood sugars above 350 for the twenty-two times recorded.<br><br>Resident # 38 was admitted to the facility on December 21, 2012, with diagnoses including Severe Sepsis, Urinary Tract Infection, Atrial | N 669 | | |

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| N 669 | Continued From page 46<br>Fibrillation, and Senile Dementia.<br><br>Medical record review of a Physician's telephone order dated January 3, 2013, revealed "...Zyvox (antibiotic) 600 mg (milligrams) IV (intravenous) Q 12 Hr (every twelve hours) x (for) 7 days...start Nitrofurantoin (antibiotic)...after completion of Zyvox..."<br><br>Medical record review of the resident's MAR for January 2013, revealed no documentation of Zyvox or Nitrofurantion administered.<br><br>Medical record review of a Physician telephone order dated January 3, 2013, revealed "...UA, C/S 1/9/13..." Continued medical record review revealed the UA C/S was reported to the facility on January 11, 2013, "...organism Enterococcus Faecalis..." with no documentation the Physician was contacted. Further review revealed the resident was discharged from the facility home with home health on January 16, 2013.<br><br>Interview on February 7, 2013, at 4:30 p.m., with NP #2 at the 200 hall nurse's station, confirmed the Physician was not notified of the results of the UA C/S reported to the facility on January 11, 2013. Interview confirmed the resident could have been treated with PO (by mouth) antibiotics.<br><br>Interview with the DON in the facility conference room on February 8, 2013, at 10:53 a.m., confirmed the facility failed to ensure the results were reported for the January 9, 2013, UA C/S, and failed to ensure medications were administered as prescribed.<br><br>Resident #42 was admitted to the facility on December 13, 2012, with diagnoses including Urinary Tract Infection, Chronic Kidney Disease, | N 669 | | |

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| N 669 | Continued From page 47<br><br>Diabetes Mellitus, Cirrhosis of the Liver, and Liver Transplant.<br><br>Medical record review of the Order Summary Report revealed order date December 18, 2012, "...Cipro (ciproflaxin) ( antibiotic) 500 mg (milligram) by mouth every 12 hours related to urinary infection...Diflucan (antifungal) 150 mg give...by mouth one time only...related to urinary tract infection..."<br><br>Medical record review of the resident MAR dated December 18, 2012, revealed "...Cipro...500 mg...not administered...Diflucan...150 mg...not administered..." Continued medical record review of a Nurse's Progress Note dated December 18, 2012, revealed "...medications not in medselect left message for pharmacy...changed time for med (medication)..." Continued review of the MAR revealed no documentation the Diflucan was ever given.<br><br>Interview with the DON, in the DON's office, on February 5, 2013, at 7:45 a.m., confirmed the medications were not provided per Physician order.<br><br>Interview with the facility Medical Director on February 13, 2013, at 1:35 p.m., confirmed resident's should receive antibiotics as soon as possible after ordering, was not notified of medications not administered.<br><br>Resident #43 was admitted to the facility on December 24, 2012, with diagnoses including Dementia, Superior Endplate Compression Fracture, Diabetes Type 2, and Hypothyroidism.<br><br>Medical record review of the residents Order Summary Report revealed order date December | N 669 | | |

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| N 669 | Continued From page 48<br><br>24, 2012, "...Diltiazem 180 mg for high blood pressure one time per day...Lovastatin (lipid lowering agent) 20 mg one time a day...Megace (appetite stimulant) 40 mg...Flagyl (antibiotic) 250 mg two times per day..."<br><br>Medical record review of the resident MAR for December 2012, revealed Diltiazem and Flagyl were not documented as given on December 25, 2012 and December 26, 2012, and Lovastatin and Megace were not documented as given on December 26, 2012. Medical record review of the resident Progress Notes dated December 25, 2012, revealed "...Medication no (not) profiled for this pt (patient) in med select.(electronic medication delivery system)..continued review of the December 26, 2012, Progress Notes revealed...med (medication) unavailable..."<br><br>Medical record review of a Physician's telephone order dated January 3, 2013, revealed "...Talacen 25/650 1 (one) PO (by mouth) q (every) 6 (six) hours PRN (as needed) for pain..."<br><br>Interview with Medical Technician #1 and MDS Nurse # 3 on January 23, 2013, at 9:08 a.m., at the 400 hall nurse's station, revealed the Talacen was ordered in the computer on January 3, 2013, at 7:00 p.m.<br><br>Interview and observation on the 400 hall, with Charge Nurse #4 of the 400 hall medication cart, on January 23, 2013, at 9:12 a.m., and review of a Controlled Substance Record revealed the Talacen was not received until January 17, 2013 (fourteen days after medication ordered).<br><br>Interview with the facility pharmacy provider by telephone, Pharmacist #1, on February 5, 2013, at 9:22 a.m., confirmed the Talacen was not sent | N 669 | | |

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| N 669 | Continued From page 49<br>until January 17, 2013.<br><br>Medical record review of a Physician's telephone order dated January 16, 2013, revealed "...Zosyn 3/375 g (grams) IV (intravenous) Q 6 hours x 7 days..."<br><br>Medical record review of the resident's MAR January 2013 revealed the Zosyn was not started until January 18, 2013, at 12:00 p.m.<br><br>Interview with the DON in the DON's office on February 5, 2013, at 1:48 p.m., confirmed the MAR and the Progress Notes indicated the medications were not administered as ordered by the Physician. Continued medical record review and interview confirmed the resident did not receive the Talacen ordered on January 3, 2013 until January 17, 2013, fourteen days after the medication was ordered and the Zosyn ordered on January 16, 2013, was not administered until January 18, 2013, two days after the initial order date. Interview confirmed the Nursing Staff of the facility were unaware Intravenous medications were to be ordered from a different Pharmacy other than the routine Pharmacy used by the facility. The physician was not notified of the medications not administered.<br><br>Interview with the Physician on January 30, 2013, at 3:10 p.m., in the facility conference room, confirmed the Physician was not notified the medications were not administered. | N 669 | | |
| N 671 | 1200-8-6-.06(4)(c)6. Basic Services<br><br>(4) Nursing Services.<br><br>(c) The Director of Nursing shall have the following responsibilities: | N 671 | | |

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| N 671 | Continued From page 50<br><br>6. Supervise the administration of medications.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility policy review, and interview, the facility failed to ensure residents were free from significant medication errors for twenty-one residents (#71, #62, #36, #44, #70, #16, #18, #19, #7, #10, #20, #34, #32, #43, #31, #2, #50, #55, #72, #35 and #28) of 79 residents reviewed. The facility's failure to administer the correct insulin dose for resident #71, failure to ensure the correct medication was administered to the correct resident for resident #62, failure to administer a medication for anticoagulation (Coumadin) as ordered for resident #36, and the facility's failure to ensure a system of correct medication transcription, failure to ensure medications were given as ordered placed all residents receiving medications in an environment which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Resident #71 was admitted to the facility on December 4, 2012, with diagnoses including Diabetes, Hypertension, and Congestive Heart Failure.<br><br>Review of a Nursing Assessment dated December 11, 2012, revealed the resident had been cognitively intact, totally dependent for all Activities of Daily Living (ADL'S), and insulin injections were received.<br><br>Medical record review of a Physician order dated December 4, 2012, at 4:33 p.m., revealed | N 671 | | |

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| N 671 | Continued From page 51<br>"...Novolin N (Insulin Isophane (Human)) Suspension twice daily...3 units..."<br><br>Medical record review of the Medication Administration Record (MAR) dated February 1-28, 2013, revealed "...Novolin N (insulin) 100 unit/ML (milliliter) Subcutaneous twice daily 100 unit/ML Suspension Subcutaneous...3 units..."<br><br>Medical record review of a Nurse Progress Note dated February 2, 2013, at 11:30 a.m., revealed "...Wrong dose of Novolin N given. Order input in the computer incorrectly and the 3 units did't show up on the first e-mar screen. 100 units showed as the dose to give. Started giving the Pt (patient)...insulin dosage and pt stopped me and stated how much are you giving? I stated 100 units and...informed me that...thought that was incorrect. I stopped giving the insulin, went to the physician orders and reviewed the complete order and noted that resident was to only get three units. Resident was given approx (approximately) 28 units.<br><br>Medical record review of a Medication Error Report dated February 2, 2013, revealed "...Comments: order input incorrectly in E-Mar System unable to view correct dosage in first screen. order corrected...Type of Incident: 3. Wrong Dose...Factors Contributing to Incident: 2. Misinterpreted order 3. Meaning of order not clear 6. Order transcribed incorrectly..."<br><br>Medical record review of a physician order clarification dated February 2, 2013, revealed "...Order clarification: Novolin N 100 Units/ml. give 3 units BID (twice daily)... (hand written)...order changed to this..."<br><br>Medical record review of a Nurse Progress Note | N 671 | | |

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| N 671 | Continued From page 52<br><br>dated February 2, 2013, at 5:37 p.m., revealed "...Novolin N...Held per Pt request..."<br><br>Interview with Licensed Practical Nurse (LPN) #10 on February 8, 2013, at 10:10 a.m., in the conference room, revealed LPN #10 had prepared 100 units of Novolin N for administration for resident #71 on February 2, 2013, entered residents room, and during administration of the insulin injection the resident stopped the nurse. Continued interview at this time revealed LPN #10 stated the order had not been transcribed correctly on the E-Mar and the dose to be given had been listed as 100 units.<br><br>Interview with the Administrator on January 24, 2013, at 1:50 p.m., in the Administrator's office, revealed the facility does not complete competency verification on medication administration on hire with licensed staff.<br><br>Interview with the Administrator on January 28, 2013, at 3:00 p.m., in the Administrator's office, revealed new nurse educator starts February 18, 2013, and the skills list/check off list for competency was the first item to be addressed. Further interview at this time confirmed, "The facility had severely neglected the skills check list for a long time."<br><br>Interview with Corporate Nurse #1 on February 7, 2013, at 1:20 p.m., in the Admission office, confirmed the facility had no procedure currently in place to check the accuracy of physician's orders put in the computer and the orders placed in the computer is how the MAR's are generated.<br><br>Interview with Registered Nurse (RN) #4 on February 12, 2013, at 9:12 a.m., by way of phone, revealed RN #4 had been hired in April 2012, as | N 671 | | |

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| N 671 | Continued From page 53<br>the nurse educator, education had not been a priority and had only served in the educator role for approximately six weeks since hire. Continued interview revealed nurses had been educated during orientation regarding putting orders in the computer and after orientation there were no audits to check if the orders had been transcribed correctly. Further interview revealed the facility had changed computer programs at the beginning of September 2012.<br><br>Resident #62 was admitted to the facility on June 15, 2012, and readmitted on February 2, 2013, with diagnoses including Digitalis Toxicity, Convulsions, and Senile Dementia.<br><br>Medical record review of a January 2012, Order Summary Report revealed no physician's order for Digoxin (cardiac medicine that slows heart rate).<br><br>Medical record review of the Medication Administration Record dated January 1-31, 2013, revealed no administration of Digoxin.<br><br>Medical record review of a Nurse's Progress Note dated January 31, 2013, at 11:15 a.m., revealed "...resident sitting in the dayroom with head down on table copius amts (amounts) of mucus noted per...resident unresponsive to verbal stimuli B/P (blood pressure) 93/54 P (pulse) 48..."<br><br>Medical record review of a Nurse's Progress Note dated January 31, 2013, at 11:25 a.m., revealed "...NP (nurse practitioner) in building notified of cond (condition)..."<br><br>Medical record review of a Nurse's Progress Note dated January 31, 2013, at 11:30 a.m., revealed " ..note new order to send...for eval (evaluation at | N 671 | | |

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| N 671 | Continued From page 54<br>hospital emeregency room) ..amb (ambulance) service notified..."<br><br>Medical record review of a Nurse's Progress Note dated January 31, 2013, at 11:55 a.m., revealed "...BP 115/56 P 46..."<br><br>Medical record review of a Nurse's Progress Note dated January 31, 2013, at 12:00, revealed "...here to transport to ER (emergency room)..."<br><br>Medical record review of the Emergency Patient Record dated January 31, 2012, revealed arrival date/time January 31, 2013, at 12:26 p.m., chief complaint Seizure, pulse 56, and fully alert.<br><br>Medical record review of a Patient Safety Parameter assessment from the ER dated January 31, 2013, at 12:44 p.m., revealed "...patient ID (identification) Band in place and validated..."<br><br>Medical record review of the History and Physical from...(named) hospital dated January 31, 2013, revealed "...sent in today for seizures...Problem list: 8. Digoxin Toxicity...supratherapeutic digoxin level...does not appear to be on Digoxin from the medication list...recheck digoxin level...will attempt to obtain a new med list at the nursing home...perhaps this is inaccurate..."<br><br>Medical record review of laboratory results from... (named) hospital revealed "...Digoxin January 31, 2013, 14:17 (2:17 p.m.) 2.4 (reference normal range 0.5-2.0)...Digoxin January 31, 2013, 18:00 (6:00 p.m.) 2.3...Digoxin February 01, 2013, 4:00 a.m., 2.3... Digoxin February 02, 2013, 3:55 a.m., 2.1..."<br><br>Medical record review of the Hospitalist Physician | N 671 | | |

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| N 671 | Continued From page 55<br><br>Discharge Summary dated February 2, 2013, revealed "...Final Discharge...Digoxin Toxicity...digoxin level of 2.4...Digoxin toxicity was discussed with facility medical Director and it was noted...should not be on Digoxin...was going to investigate digoxin on that end..."<br><br>Medical record review of a Nurse Progress Note dated February 2, 2013, at 5:32 p.m., revealed "...resident arrived via ambulance at apx (approximately) 16:30 (4:30 p.m.) Pulse 55...reported from...digoxin toxicity (2.3)..."<br><br>Medical record review of a laboratory test drawn February 5, 2013, revealed < (less than) 0.2 reference range for this lab 0.9-2.0..."<br><br>Interview with Nurse Practitioner (NP) #3 on February 6, 2013, at 10:12 a.m., in the conference room, revealed the signs and symptoms of digoxin toxicity would be yellow halo (visual yellow ring), fatigue, bradycardia (low pulse) and nausea.<br><br>Interview with the Corporate Nurse #1 on February 6, 2013, at 1:10 p.m., in the Director of Nursing (DON) office, revealed the Medical Director had notified the Corporate Nurse of the resident's diagnosis of Digoxin Toxicity on February 1, 2013, by way of phone. Continued interview revealed the Corporate Nurse notified the DON.<br><br>Interview with the Director of Nursing (DON) on February 6, 2013, at 1:15 p.m., in the DON office, revealed the resident had been admitted to the hospital with a diagnosis of Digoxin Toxicity and stated unaware the resident received Digoxin at the facility. The DON stated the facility checked the medication cart and found no Digoxin for this | N 671 | | |

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| N 671 | Continued From page 56<br>resident.<br><br>Interview with LPN #11 on February 6, 2013, at 4:40 p.m., in the East Wing Nurse's Station, revealed LPN #11 had checked the resident's medication drawer on February 1, 2013, found no Digoxin, and had not administered Digoxin to the resident.<br><br>Interview with Pharmacist #1 on February 7, 2013, at 10:15 a.m., by way of phone, revealed the pharmacy has no records Digoxin had been sent to resident #62.<br><br>Interview with Laboratory Director of the... (named) hospital on February 7, 2013, at 10:22 A.M., by way of phone, revealed the hospital ER had a phlebotomist (blood technician) assigned to the ER, ER ordered test, request prints out, the phlebotomist takes the request to the bedside, identity is verified with identification band (name and account number), the arm band was placed on residents at arrival to the ER, and phlebotomist do not draw blood without an identification band in place. Continued interview at this time revealed unaware of any other medications that would be identified as Digoxin on a Digoxin Level.<br><br>Interview with the Emergency Room physician on February 11, 2013, at 1:52 p.m., by way of phone, revealed the physician had reviewed the medication list prior to examining the patient. The patient had bradycardia (low pulse) and a Digoxin level had been ordered. Further interview at this time revealed the Digoxin level had been elevated and the test had been redrawn to confirm the test results. The physician revealed the laboratory test for Digoxin was not an error due to multiple blood draws had been performed for this | N 671 | | |

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| N 671 | Continued From page 57<br>resident.<br><br>Resident #36 was admitted to the facility on August 12, 2012, and readmitted on September 7, 2012, with diagnoses including Aortic Valve Disorder, Methicillin Resistant Staphylococcus Aureus (MRSA) (contagious infection), Cerebrovascular Disease, and Hemiplegia Dominant Side.<br><br>Medical record review of an Interdisciplinary Care Plan first initiated August 23, 2012, revealed: potential for uncontrolled bleeding, administer anticoagulant as ordered, monitor coagulation studies as ordered, and report to physician.<br><br>Medical record review of a Order Summary Report dated November 1-30, 2012, revealed "...Coumadin 8mg every HS (at night)..."<br><br>Medical record review of a lab report for PT/INR (Protime/International Normalization Ratio (lab test for blood clotting) dated November 26, 2012, revealed PT 49.2 (normal range 9-11), and INR 4.9 (normal range .90-1.10).<br><br>Medical record review of a Physician's Telephone Order dated November 26, 2012, revealed "...d/c (discontinue) Coumadin (anticoagulant)...PT/INR (Protime/International Normalization Ratio (lab test for blood clotting) on 11/28 call NP (Nurse Practitioner)/MD (Medical Doctor) for new Coumadin orders with results..."<br><br>Medical record review of a Nurse Practitioner Note dated November 26, 2012, revealed "...discontinue Coumadin...it will remain on hold until 11/28/12 when we will recheck PT/INR...values will be reviewed and orders for Coumadin will be reestablished at that time..." | N 671 | | |

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| N 671 | Continued From page 58<br><br>Medical record review of the Medication Administration Record (MAR) dated November 1, 2012, through November 30, 2012, revealed "...Coumadin 8 mg (milligram) every HS (hours of sleep) for thick blood...dc (discontinue) 11/27/12..."<br><br>Medical record review of a lab report PT/INR dated November 28, 2012, revealed PT 20.4 and INR 2.0.<br><br>Medical record review of a Physician's Progress Note dated November 28, 2012, revealed "...continue Coumadin at current dose..."<br><br>Medical record review of the MAR revealed the Coumadin was not restarted on November 28, 2012, and no Coumadin was administered November 29 and 30, 2012.<br><br>Medical record review of the MAR dated December 1, 2012, through December 31, 2012, revealed "...Coumadin 6 mg start date 12/21/12..."<br><br>Medical record review of a Physician's Telephone Order dated December 20, 2012, revealed "...Coumadin 6 mg PO (by mouth) QD (every day) Dx: (diagnosis) Aortic Valve Replacement...PT/INR 12/27/12..."<br><br>Medical record review of a PT/INR dated December 27, 2012, revealed PT 14.2, and INR 1.4.<br><br>Interview with the Assistant Director of Nursing on January 23, 2013, at 10:00 a.m., at the Center Wing Nurse's Station, confirmed the facility failed to follow the Physician's Order on November 28, | N 671 | | |

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| N 671 | Continued From page 59<br><br>2012, and the Coumadin was not administered for twenty-two days, until December 21, 2012.<br><br>Interview with NP #2 on January 24, 2013, at 1:00 p.m., in the East Wing Nurse's Station, confirmed the NP had been notified of the PT/INR results on November 28, 2012, the NP had given an order to continue Coumadin at the current dose, the NP discovered on December 20, 2012, the resident's anticoagulation therapy was on hold since November 28, 2012 (twenty-two days), a telephone order was written on December 20, 2012, to give Coumadin 6 mg po qd, and the facility restarted the Coumadin on December 21, 2012. Further interview at this time confirmed the resident will always be on Coumadin due to diagnoses of Aortic Valve Replacement and history of Deep Vein Thrombosis, the resident's target INR is 2.5-3.5. The NP stated after three to four days a patient would not be anticoagulated, and without the Coumadin therapy the resident had been placed at a high risk for a recurrent stroke (clots to brain).<br><br>Interview with the Medical Director (MD) on January 30, 2013, at 11:00 a.m., in the conference room, revealed resident #36 required Coumadin on a routine basis. Continued interview confirmed the MD was aware the facility failed to continue the Coumadin at the current dose on November 28, 2012, and the resident had not received Coumadin for twenty-two days. Further interview at this time confirmed this placed the resident at high risk for Stroke, Blood Clots, and a Deep Vein Thrombosis.<br><br>Resident #44 was admitted to the facility on December 21, 2012, with diagnoses including Pneumonia, Hypertension, Depressive Disorder, and Senile Dementia. The resident was | N 671 | | |

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| N 671 | Continued From page 60<br>discharged from the facility on January 8, 2013.<br><br>Medical record review of a Hospital Consultation Report dated December 17, 2012, revealed "...The organism (bacteria in the lungs-caused the pneumonia) is universally sensitive to...aerosolization of gentamicin (antibiotic) 100 mg (milligrams) twice daily should facilitate clearing of...aspiration pulmonary infection...The inhaled gentamicin can be given along the way and...may be required to remain in a facility while...recovers..."<br><br>Medical record review of the Hospital Discharge Orders dated December 21, 2012, revealed "...Gentamicin Sulfate...100 mg INH (inhalation) every 12 hours x 7 days..."<br><br>Medical record review of the Medication Administration Record dated December 2012, revealed "...Gentamicin Sulfate...Use 100 mg intravenously every 12 hours for infection until 12/28/2012"<br><br>Medical record review of the Medication Administration Record dated December 2012, revealed the resident received the Gentamicin 100 mg intravenously on December 22, 2012, at 8:00 p.m., December 23, 2012, at 8:00 a.m., December 24, 2012, at 8:00 p.m., December 25, 26, 27, and 28, 2012, at 8:00 a.m. and 8:00 p.m. (11 doses).<br><br>Interview on February 6, 2013, at 10:15 a.m., with Nurse Practitioner #3, in the conference room, confirmed the wrong route of the Gentamicin was administered the resident. (given intravenously instead of by inhalation) Continued interview confirmed 100mg Gentamicin would not have been a proper dose for IV rate. | N 671 | | |

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| N 671 | Continued From page 61<br><br>Interview on February 6, 2013, at 1:25 p.m., with Licensed Practical Nurse (LPN) #25, by telephone, confirmed the order for the Gentamicin had been transcribed incorrectly.<br><br>Resident #70 was admitted to the facility on June 4, 2012, and readmitted on January 4, 2013, with diagnoses including Alzheimer's Disease, Pneumonia, and Hypertension.<br><br>Medical record review of a Hospitalist Discharge Summary revealed the resident was discharged from the hospital on January 4, 2013. Continued review of the Hospitalist Discharge Summary revealed "...Final Discharge Diagnoses: 1. Pneumonia. 2. Hypertension. 3. Urinary Tract Infection-Escherichia coli/Enterococcus faecalis. 4. Fever. 5. Leukocytosis. 6. Acute Renal Failure. 7. Dementia...A percutaneous endoscopic gastrostomy tube was declined and ultimately, the decision was made for hospice care at the nursing home and...was discharged on January 4 to (facility).<br><br>Medical record review of a Nurse Practitioner's order dated January 15, 2013, revealed the resident was to received Roxanol (morphine) 5 mg. (milligrams) SL (under the tongue) every 4 hours as needed for pain, restlessness, or shortness of breath.<br><br>Medical record review of a nurse's progress not dated January 18, 2013, at 1:15 a.m., revealed "Resident found without breath sounds, respirations or heart beat. Family at bedside due to anticipated death due to decline in health. Resident pronounced dead at 0115am."<br><br>Medical record review of the January 2013, | N 671 | | |

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| N 671 | Continued From page 62<br><br>Medication Administration Record revealed no documentation the resident had received the Roxanol.<br><br>Medical record review of a Controlled Substance Record revealed the Roxanol was obtained from the back-up pharmacy on January 17, 2013. Continued of the Controlled Substance Record revealed one dose of the Roxanol was signed out for the resident on January 17, 2013, at 11:15 p.m., by LPN #28.<br><br>Telephone interview on February 8, 2013, at 10:35 a.m., with Pharmacist #1 revealed the Roxanol was profiled (made available) in Med Select (secure electronic medication cabinet) on January 15, 2013. Continued interview revealed there were "issues" with the facility nurses saying the Roxanol was not available. Pharmacist #1 stated the order for the Roxanol was called to the back-up pharmacy on January 17, 2013, and the resident's family had not wanted to wait for the courier to bring the Roxanol to the facility. Pharmacist #1 stated the family had picked up the Roxanol from the back-up pharmacy and delivered the Roxanol to the facility for administration to the resident.<br><br>Telephone interview on February 8, 2013, at 11:10 a.m., with Nurse Practitioner (NP) #1 revealed NP #1 had written the order for the Roxanol on January 15, 2013, because NP #1 thought the Roxanol was available for administration to the resident and the resident was uncomfortable. Continued interview revealed resident #70 was struggling with breathing, was moaning, and restless. Continued interview revealed the medication was necessary and it was NP #1's opinion resident #70 suffered if the medication was not administered. | N 671 | | |

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| N 671 | Continued From page 63<br><br>Interview on February 8, 2013, at 1:50 p.m., with LPN #26, in the hallway revealed the Roxanol was ordered on a day LPN #26 did not work. Continued interview revealed when LPN #26 had returned to work LPN #26 had tried to obtain the Roxanol for the resident. Continued interview revealed LPN #26 had called the pharmacy and was told the Roxanol was available in the Med Select (secure medication cabinet). Continued interview revealed there were three Med Selects located on the Center, North, and West wings. Continued interview with LPN #26 revealed LPN #29 had tried to obtain the Roxanol from the three Med Selects and was unable to obtain the Roxanol from the Med Selects. Continued interview revealed LPN #29 had told LPN #28. Continued interview revealed LPN #28 had been on the telephone with the pharmacy trying to obtain the Roxanol, and the next morning the resident had died.<br><br>Telephone interview on February 12, 2013, at 11:15 a.m., with LPN #27, revealed on January 15, 2013, the day the Roxanol was ordered, the resident had been grimacing with pain and Tylenol was administered to the resident because the Roxanol was not available. Continued interview revealed the family had wanted the resident to receive the Roxanol because they thought the resident was in pain and they wanted the resident to rest.<br><br>Telephone interview on February 8, 2013, at 10:55 a.m., with LPN #29 revealed LPN #29 recalled the order for resident #70's Roxanol and the situation, of the unavailability of the Roxanol, had made LPN #29 "mad." Continued interview revealed LPN #29 had gone to all three Med Selects in the facility and the medication was not | N 671 | | |

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| N 671 | Continued From page 64 | N 671 | | |

available; continued interview revealed LPN #29 had been on the telephone a long time with the pharmacy trying to obtain the medication. LPN #29 stated on the day the resident died thought the resident had suffered, had difficulty breathing, the eyes were squeezed shut, and the resident had grimaced.

Telephone interview on February 12, 2013, at 8:55 a.m., with LPN #28 revealed the resident had expired when LPN #28 was responsible for the resident's care. Continued interview revealed resident #70's family had been at the facility on January 17, 2012, and had asked LPN #28 "what do we have to do to get (the resident's) Roxanol." Continued interview revealed LPN #28 had called to get a courier to go to the back-up pharmacy to obtain the Roxanol. Continued interview revealed the facility "waited and waited and waited" and the courier did not arrive. Continued interview revealed the back-up pharmacy was called again and had been very busy, and stated the resident's family could pick-up the Roxanol at the back-up pharmacy. Continued interview revealed the resident's family had obtained the Roxanol from the back-up pharmacy. LPN #28 stated the resident's family had thought the resident might be hurting, were upset and crying, and wanting the resident to be made comfortable. Continued interview revealed LPN #28 had administered the Roxanol to the resident approximately one hour before the resident expired.

Interview on February 13, 2013, at 1:00 p.m., with the facility's Medical Director, in the admission office, confirmed it was unacceptable for residents to not receive pain medications as ordered.

Resident #16 was admitted to the facility on

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| N 671 | Continued From page 65<br><br>November 15, 2012, with diagnoses including Pneumonia, Chronic Airway Obstruction, Cerebrovascular Disease, Diabetes, Chronic Pain, Depressive Disorder, and Malignant Neoplasm Bronchus and Lung.<br><br>Medical record review of the nursing notes revealed the resident was discharged home on December 8, 2012.<br><br>Medical record review of the admission physician's orders dated November 15, 2012, revealed the resident was to receive nitroglycerin (antianginal) 2.5 mg. (milligrams) every eight hours, and oxybutynin (incontinence medication) 5 mg. three times a day.<br><br>Medical record review of the November 2012, Medication Administration Record (MAR) revealed the nitroglycerin was initialed as administered by LPN #20 at 4:00 p.m., on November 15, 2012, and the oxybutynin was initialed as administered by Licensed Practical Nurse (LPN) #20 on November 15, 2012, at 5:00 p.m. Continued review of the November 2012, MAR revealed LPN #7 had documented on November 15, 2012, at 8:00 p.m., the nitroglycerin and the oxybutynin a (9) in the box with the initials indicating to see the nursing notes.<br><br>Medical record review of the nursing notes prepared by LPN #7 on November 15, 2012, at 9:33 p.m., the facility was awaiting delivery of the medications from the pharmacy.<br><br>Interview on January 29, 2013, at 7:55 a.m., with LPN #20 revealed the nitroglycerin and the oxybutynin were obtained from the resident's medications on the medication cart, or from the | N 671 | | |

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| N 671 | Continued From page 66<br>med select system.<br><br>Telephone interview on January 29, 2013, at 10:45 a.m., with Pharmacist #1, revealed the resident's medications were delivered to the facility on November 15, 2012, around midnight. Continued interview revealed the nitroglycerin was not available for administration to the resident until November 15, 2012, around midnight. Continued interview revealed the oxybutynin was available from med select (secure electronic medication cabinet), however, had not been obtained from med select.<br><br>Resident #18 was admitted to the facility on November 10, 2012, with diagnoses including severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Senile Dementia, Esophageal Reflux, and Gastrostomy.<br><br>Review of the discharge medication list from the discharging hospital dated November 10, 2012, revealed the following medications: " ...CONTINUE taking these medications ...Acetominophen q 4 hr PRN (every 4 hours as needed), Albuterol Sulfate 1 puff every 4 hours as needed. Aspirin EC 1 mg (milligrams) oral daily, Escitalopram Oxalate (Lexapro)10 mg oral twice daily, Fluconazole 100 mg per tube daily x (times) 7 days. Metoprolol succinate (Toprol) 50 mg oral bedtime, Mirtazapine (Remeron) 15 mg oral bedtime, Multivitamins, Ther w-(With) Minerals 1 tab oral daily. Pantoprazole sodium 40 mg oral or per tube daily, Quetiapine Fumarate (Seroquel) 12.5 mg oral twice daily, Quetiapine Fumarate 25 mg oral bedtime, Rivastigmine (Exelon) 9.5 mg transderm (patch) daily, Valsartan (Diovan) 160 mg oral daily... " Further review revealed " STOP taking these medications...Hydrochlorothiazide 25 mg oral | N 671 | | |

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| N 671 | Continued From page 67<br>daily, Potassium Chloride 40 meq (milliequivelant) oral daily... "<br><br>Medical record review of the November 2012, Medication Administration Record (MAR) revealed " x " for November 10, 11, and 12, 2012.<br><br>Review of facility policy, dated 2003; Rev 2010, entitled "...F. Admission Process to the Unit...Procedure 9. Review transferring facility' s recommendations and notify the attending physician to approve or change the recommendations to the admission orders and obtain additional orders if required...11. Enter the admitting physician orders in the electronic medical record...12. Process medications and other orders... "<br><br>Interview with Licensed Practical Nurse (LPN) #23 on January 22, 2013, at 1:10 p.m., in the conference room confirmed the " x " on the MAR meant the "...medication was not started at the time due to the medication was not ordered at that time to be administered... "<br><br>Interview with Licensed Practical Nurse (LPN) #22, on January 22, 2012, at 2:00 p.m., at the300 nursing station, confirmed LPN #22 was the admission nurse for resident #18 on November 10, 2012. Further interview confirmed the admission orders were not verified and the medication was not administered as ordered on November 10, 11 or 12, 2012.<br><br>Resident #19 was admitted to the facility on November 9, 2012, with diagnoses including Cerebrovascular Disease, Guillain-Barre syndrome, Coronary Artery Disease, Hypertension, Dementia, Osteoporosis, Chronic | N 671 | | |

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| N 671 | Continued From page 68<br><br>Obstructive Pulmonary Disease, Atrial Fibrillation, and Acute on Chronic Renal Failure.<br><br>Medical record review of a Nurse Practitioner's note dated December 11, 2012, revealed "...Today, I have been asked by nursing staff to evaluate a recent urinalysis and culture and sensitivity report...most definitely has a urinary tract infection. This culture and sensitivity report was unfortunately misplaced and is several days old...Today, I will move forward with treatment of this positive urinary tract infection. I will place...on Cipro (antibiotic) 500 mg. to be taken q. (every) 12 hours for a duration of seven days...is most certainly prone to urinary tract infections secondary to...history of constipation..."<br><br>Medical record review of a physician's order dated December 11, 2012, revealed the resident was to receive Cipro 500 mg. by mouth every twelve hours for seven days.<br><br>Medical record review of the December 2012, Medication Administration Record (MAR) revealed the Cipro was transcribed as follows, "Cipro Tablet 500 mg, give 1 tablet by mouth every 12 hours every 7 day(s) for infection until 12/19/2012..." Continued review of the December 2012, MAR revealed the only dose of the ordered Cipro 500 mg. administered was on December 19, 2012, at 8:00 p.m., the resident did not receive 14 doses of the Cipro, every twelve hours as ordered.<br><br>Medical record review of a Nurse Practitioner's note dated January 7, 2013, revealed "...Today, I have been asked by nursing staff to review a culture and sensitivity report which was performed on...urine. In looking through the history, it appears that...has not been treated | N 671 | | |

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| N 671 | Continued From page 69<br><br>appropriately for...current urinary tract infections. The orders were in fact written appropriately for Cipro to be used on a b.i.d. (twice a day) basis for a duration of seven days. Unfortunately, the medication has been erroneously given. It appears that it is only being given every seven days. The culture unfortunately has grown out a bacteria which is only intermediately sensitive to Cipro which would indicate a potential growing resistance...will be placed on Bactrim DS (sulfa drug for treatment of Urinary Tract Infections) one tablet to be taken q (every) 12 hours for a duration of 10 days..."<br><br>Medical record review of the hospital discharge medications dated November 9, 2012, for resident #19 revealed the resident was to receive the following medications: amlodipine (antihypertensive) 5 mg once daily; benazepril (antihypertensive) 20 mg once daily; clonidine 0.1 mg every six hours as needed for systolic blood pressure greater than 170; clopidogrel (medication to reduce thrombotic events) 75 mg once daily; levetiracetam (anticonvulsant) 500 mg twice daily; metoprolol (antihypertensive) 200 mg daily; mirtazapine (antidepressant) 22.5 mg once daily at bedtime; and pravastatin (antilipemic) 40 mg once daily.<br><br>Medical record review of the November 2012, Medication Administration Record (MAR) revealed no medications were administered until November 11, 2012, except the Pravastatin initialed as administered on November 9, 2012, at 9:00 p.m., and levetiracetam initialed as administered on November 9, 2012, at 8:00 p.m., by a nurse no longer employed at the facility.<br><br>Medical record review revealed no documentation the resident's blood pressure was checked | N 671 | | |

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| N 671 | Continued From page 70<br>except on November 13, 2012, when the blood pressure was 139/70.<br><br>Review of a Consolidated Delivery Sheet (pharmacy log delivery sheet) revealed the clonidine was delivered and received by the facility on November 12, 2012, at 11:30 p.m., and the other medications were received on November 13, 2012, at 11:45 p.m.<br><br>Telephone interview on January 23, 2013, at 9:35 a.m., with Pharmacist #1 revealed the pharmacy was not made aware of resident #19's need for the prescriptions to be filled until November 11, 2012, (two days after admission to the facility). Continued interview confirmed the medications were not available for administration to the resident until November 11, 2012.<br><br>Interview on January 23, 2012, at 9:50 a.m., with the Director of Nursing, in the conference room, confirmed the resident did not receive the amlodipine, benazepril, clopidogrel, levetiracetam, metoprolol, mirtazapine, and the pravastatin as ordered by the physician until November 11, 2012.<br><br>Observation on January 22, 2013, at 1:10 p.m., revealed the resident seated in a wheelchair, at the bedside, eating lunch.<br><br>Interview on January 23, 2013, at 7:30 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the Cipro 500 mg. ordered every twelve hours for seven days ordered on December 11, 2012, was transcribed incorrectly, and confirmed the resident did not receive the Cipro as ordered for treatment of a Urinary Tract Infection. | N 671 | | |

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| IMPERIAL GARDENS HEALTH AND REHABILITATION | 306 W DUE WEST AVE MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| N 671 | Continued From page 71<br><br>Resident #7 was admitted to the facility on November 5, 2012, at 3:00 p.m., with diagnoses including Cerebrovascular Accident with Left Hemiparesis, Obstructive Chronic Bronchitis, Chronic Respiratory Failure, Epilepsy, Hypertension, Senile Dementia, and Dysphagia.<br><br>Review of the Edit Census Entry revealed the resident was admitted to the facility on November 5, 2012, at 3:00 p.m., and discharged home on November 6, 2012, at 4:00 p.m.<br><br>Medical record review of resident #7's admission orders revealed the resident was to receive the following medications: Enoxaparin (anticoagulant) 40 mg. (milligrams) subcutaneously every 24 hours; citalopram (antidepressant) 40 mg daily; clopidogrel (platelet medication) 75 mg daily; losartan potassium (antihypertensive) 25 mg daily; aspirin 81 mg daily; bupropion SR (antidepressant with sustained release) 150 mg twice daily; phenytoin sodium extended (anticonvulsant) 300 mg daily; and pantoprazole sodium (anti-ulcer) 40 mg daily.<br><br>Medical record review of a nursing note dated November 5, 2012, at 9:44 p.m., revealed "hour of Administration note pts (patients) meds (medications) not in or medselect."<br><br>Medical record review of the November 5 and 6, 2012, Medication Administration Record revealed no documentation the resident received the medications as ordered.<br><br>Telephone interview on January 23, 2013, at 9:35 a.m., with Pharmacist #1 revealed the pharmacy never received any orders from the facility for the resident's medications. | N 671 | | |

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| N 671 | Continued From page 72<br><br>Interview on January 23, 2013, at 9:50 a.m., with the Director of Nursing, in the conference room, confirmed the resident's medications were not administered.<br><br>Resident #10 was admitted to the facility on November 2, 2012, with diagnoses including Malignant Neoplasm of Uterus, Urinary Tract Infection, Hypertension, Depressive Disorder, and Diabetes. The resident expired at the facility on November 28, 2012.<br><br>Medical record review of a physician's order dated November 2, 2012, revealed "...Morphine Sulfate (a narcotic) 15mg (milligrams) Tablet oral...PRN (as needed)...1-2 tabs Q (every) 3 (hours) PRN For Breakthrough Pain...MS Contin (Morphine Sulfate) 75mg Tablet Extended Release (the total dose is released slowly over the course of hours) 12 Hour oral (By mouth) -twice daily everyday..."<br><br>Review of the Controlled Substance Record dated November 3, 2012, revealed "...Morphine Sulfate IMM REL (immediate release the effects of the full dose are felt immediately) 15 mg (milligram) tab...11/9 (2012) 2000 (8:00) pm...amount given 5 (tablets)..."<br><br>Medical record review of the (Nursing) Progress Notes dated November 10, 2012, 10:24 (10:24 a.m.), revealed "...resident is sleeping and is very groogy (groggy) so morphine sulfate extended release 75 mg is being held..."<br><br>Interview on January 29, 2013, at 2:45 p.m., with the Director of Nursing (DON), in the DON's office confirmed a significant medication error occurred when Morphine Sulfate 15 mg 5 tablets were administered on November 9, 2012. | N 671 | | |

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| N 671 | Continued From page 73<br><br>Interview on February 13, 2013, at 7:45 a.m., with the Assistant Director of Nursing, in the Admission office, confirmed, "the nurse probably gave 5 tablets of the Morphine Sulfate 15 mg immediate release since the Morphine Sulfate Extended Release 15 mg and 60 mg were not available."<br><br>Resident #20 was admitted to the facility on May 10, 2012, and readmitted December 8, 2012, with diagnoses including Urinary Tract Infection, Diabetes, Advanced Vascular Disease, Chronic Pain, Above Knee Amputee, Pneumonia, and Thrombus Right Arm.<br><br>Medical record review of the resident's chart revealed the resident had been readmitted to the facility after a hospital stay on December 8, 2012, and no admission orders in the chart.<br><br>Medical record review of the Discharge Summary from the hospital dated December 8, 2012, revealed "...Discharge Instructions: Medications: Duo Nebulizer (breathing) treatments...inhale every 4 hours while awake...Plavix (prevent blood clots) 75 mg daily...Coumadin (blood thinner) 5 mg daily...Zocor (lowers cholesterol) 40 mg at bedtime...Lortab Elixir (narcotic pain medication) 7.5/500 per 15 ml, 15 mg every 4 hours as needed....Protonix (treats esophagitis) 40 mg twice daily...Humulin R (Insulin) subcutaneous sliding scale..."<br><br>Medical record review of a Nurse Progress Note dated December 8, 2012, at 7:43 p.m., revealed "...resident readmitted to facility...DVT (Deep Vein Thrombus-blood clot) in right arm..."<br><br>Medical record review of the December 2012, | N 671 | | |

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| N 671 | Continued From page 74<br><br>MAR revealed the following meds had not been administered as ordered after the readmission on December 8-12, 2012, Plavix 75 mg and Coumadin 5 mg.<br><br>Interview with Licensed Practical Nurse (LPN) #2 on February 5, 2013, at 9:50 a.m., in the Central Hall, revealed the LPN had done the readmission on December 8, 2012. Continued interview revealed the IPN used the hospital discharge orders when the resident returned to the facility. Further interview revealed the LPN had received extra training with the Point Click Care (computer software used for entering physician orders) and "still unsure of process."<br><br>Medical record review of a Physician Progress Note dated December 10, 2012, revealed "...Today, I have been asked by nursing staff to review...readmission medication orders...was treated for both MRSA (methicillin Resistant Staph Aureus) and VRE in...urine...pneumonia...being treated for a right arm non-occlusive thrombus...right arm is swollen and painful to touch...swelling...extends from the dorsum of his hand up to axilla...Assessment: Right upper extremity non-occlusive thrombus...severe peripheral vascular disease...Plan: continue with...antibiotics...continue...on Lovenox...support in all methods possible including pain control...Lortab 7.5/500 mg (milligram) to be taken q (every) eight hours...nursing to monitor this closely as this discomfort level associated with that right arm is quiet clear..."<br><br>Medical record review of a Physician's Telephone Order dated December 10, 2012, revealed Lovenox 80 mg SC (subcutaneous) Q (every) 12 hrs (hours) (thrombus R (right) arm)..." | N 671 | | |

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| N 671 | Continued From page 75<br><br>Medical record review of the MAR dated December 2012, revealed the Lovenox 80 mg SC Q 12 hrs and had been ordered on December 10, 2012, and the Lovenox had not been administered till December 11, 2012.<br><br>Medical record review of a Nurse Progress Note dated December 12, 2012, at 9:41 a.m., revealed transferred to ER (emergency room).<br><br>Medical record review of a Hospital Discharge dated December 14, 2012, revealed "...Urinary Tract Infection...History of Stroke...History of Cerebrovascular Accident...Peripheral Vascular Disease urinalysis consistent with urinary tract infection...chest x-ray showed pneumonia possibly aspiration in this setting...INR (International Normalization Ratio) 1.2...White Count 16.7 ..placed on IV (intravenous) antibiotics...Discharge Instructions: Medications: Levaquin (antibiotic) 750 mg every 24 hours for 4 doses...Plavix 75 mg daily...Coumadin 5 mg daily..." (no order for Heparin (blood thinner))<br><br>Medical record review of a MAR dated December 1-31, 2012, revealed "...Levaquin 750 mg (first dose December 17, 2012, at 8:00 a.m.)...Heparin 5000 units SQ (first dose December 16, 2012, at 12:00 a.m.)<br><br>Medical record review of a Nurse Progress Note dated December 15, 2012, at 12:04 a.m., revealed the resident was readmitted and "instructed by Registered Nurse #4 to pass admission to first shift due to staffing issues."<br><br>Medical record review of a Physician Progress Note dated December 18, 2012, revealed "...appears slightly uncomfortable...recurrent | N 671 | | |

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| N 671 | Continued From page 76<br><br>UTI's and Pneumonia ..Current Medications: Levaquin, Plavix, Coumadin, and Lortab (no dosage listed)...Plan: finish up antibiotics..."<br><br>Medical record review of a Physician Progress Note dated December 26, 2012, revealed "...12/12...respiratory distress...chest x-ray showed Pneumonia ...currently on Heparin Subcutaneous injections...was discharged from hospital on 12/14 on 5 mg of Coumadin and on 12/15 was switched back to Heparin (no physician order)...exhibit grimacing and moaning when right arm is elevated...does have a thrombosis...start Coumadin 5 mg q hs...check INR every 3 days when INR between 2 and 3 discontinue heparin..."<br><br>Interview with Consultant Nurse #1 on February 6, 2013, at 9:40 a.m., in the Director of Nursing office confirmed the facility failed to follow physician's orders for antibiotics, narcotic pain medication, and anticoagulants, and the resident was readmitted to the hospital four days later (December 12, 2012). Continued interview at this time confirmed on December 14, 2012, had been readmitted to the facility. Further interview at this time revealed the facility failed to follow physician's orders for antibiotics, and anticoagulants.<br><br>Resident #34 was admitted to the facility on March 22, 2012, with diagnoses including Osteoporosis, Diabetes, and Hypothyroidism. The resident expired at the facility on December 5, 2012.<br><br>Medical record review of a physician's order dated October 29, (2012), revealed "...UA (urinalysis) C&S (culture and sensitivity) for AMS (altered mental status)..." | N 671 | | |

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| N 671 | Continued From page 77<br><br>Medical record review of a laboratory report dated October 29, 2012, for a urine culture revealed, "...organism 1 Klebsiella Pneumoniae ESBL (Extended Spectrum B-Lactamase)...colony count (greater than) 100,000...sensitive to gentamycin (antibiotic)..."<br><br>Medical record review of a physician's order dated October 31, 2012, revealed "...d/c (discontinue) Cipro (antibiotic)...Gentamicin 60 mg (milligrams) IM (intramuscular) QD (everyday) x 7 days..."<br><br>Medical record review of the (Nurse's) Progress Notes dated November 2, 2012, 05:53 revealed "...Note...Med (medication-Gentamicin) unavailable..."<br><br>Medical record review of a physician's order dated November 4, 2012, revealed "...transfer to (named) ER (emergency room) for (complaints of) chest pain..."<br><br>Medical record review of a hospital history and physical dated November 4, 2012, revealed "...having some confusion at this time and altered mental state which is felt related to the urinary tract infection...urine sample was sent and showed Klebseilla pneumonia ESBL. Initially while pending culture information, ciprofloxacin was started...culture information was returned...determined that the organism was resistant to Cipro, medication was stopped and it appears that gentamicin was ordered. According to family member, the gentamicin took several days to arrive...now presents...with altered mental state, evidence of urinary tract infection..."<br><br>Medical record review of a Hospital Discharge | N 671 | | |

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| N 671 | Continued From page 78<br><br>Summary dated November 19, 2012, revealed "...Final Discharge Diagnoses:...Altered mental status/encephalopathy...Urinary tract infection...Recent history of urinary tract infection-ESBL Klebsiella...repeat urinalysis was unremarkable. Blood cultures were negative..."<br><br>Interview on January 30, 2013, at 9:00 a.m., by telephone with Pharmacist #3, confirmed the order for the Gentamicin 60 mg (ordered October 31, 2012) was not received until November 2, 2012, at 2:52 a.m. Continued interview confirmed the Gentamicin was filled, sent that evening, and no charges were billed for the Gentamicin from the med select (locked medication cabinet).<br><br>Interview on January 30, 2013, at 9:25 a.m., with the Assistant Director of Nursing (ADON), in the hall, confirmed pharmacy services were not provided timely.<br><br>Resident #32 was admitted to the facility on November 8, 2012, with diagnoses including Severe Sepsis, Diverticulitis, and Chronic Kidney Disease. The resident was discharged from the facility on December 21, 2012.<br><br>Medical record review of the hospital discharge medication list dated November 8, 2012, revealed "...MS (Morphine Sulfate) Contin (extended release-ER) 15 mg (milligrams) po (by mouth) (every) 12 (hours)...Rocephin (antibiotic) 2 gm (grams) IV (intravenously) qday (everyday) x 4 weeks..."<br><br>Medical record review of the Medication Administration Record dated November 2012, revealed the Rocephin was not administered on November 11, 2012, and November 16, 2012. | N 671 | | |

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| N 671 | Continued From page 79<br><br>Medical record review of the Medication Administration Record dated November 2012, revealed the MS Contin 15 mg was initialed as administered on November 10, 2012, at 8:00 a.m. by Licensed Practical Nurse #20.<br><br>Medical record review of the Controlled Substance Record for the Morphine Sulfate ER 15 mg dated November 12, 2012, revealed the first dose of Morphine Sulfate was signed out and administered on November 12, 2012, at 8:00 a.m.<br><br>Medical record review of the (Nurse's) Progress Notes dated November 11, 2012, at 04:14 (a.m.), revealed "...spoke with...at (named pharmacy) said need hard script (handwritten prescription-paper copy) for pts (patients) morphine, np (nurse practitioner) aware..."<br><br>Medical record review of the (Nurse's) Progress Notes dated November 11, 2012, at 20:34 (8:34 p.m.) revealed "...Med not available..."<br><br>Medical record review of the (Nurse's) Progress Notes dated November 12, 2012, at 06:33 (6:33 a.m.) revealed "...pts (patient's) morphine from (named pharmacy) came in..."<br><br>Medical record review of the Controlled Substance Record for the Morphine Sulfate ER 15 mg dated November 12, 2012, revealed 6 tablets were delivered to the facility.<br><br>Medical record review of the Medication Administration Record dated November 2012, revealed the resident did not receive the Morphine Sulfate 15 mg from November 15, 2012, until November 17, 2012, at 9:00 p.m.<br><br>Medical record review of the (Nurse's) Progress | N 671 | | |

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| N 671 | Continued From page 80<br><br>Notes dated November 16, 2012, revealed "...Need hard script, on order..."<br><br>Interview on February 8, 2013, at 10:30 a.m., with the Director of Nursing, in the Assistant Director of Nursing office, confirmed a delay in pharmacy services.<br><br>Resident #43 was admitted to the facility on December 24, 2012, with diagnosis including Dementia, Superior Endplate Compression Fracture, Diabetes Type 2, and Hypothyroidism.<br><br>Medical record review of the Physician Order Summary Report revealed order date December 24, 2012, " ...Diltiazem 180 mg (milligrams) for high blood pressure one time per day...Lovastatin (lipid lowering agent) 20 mg one time a day...Megace (appetite stimulant) 40 mg...Flagyl (antibiotic) 250 mg two times per day..."<br><br>Medical record review of the resident Medication Administration Record for December 2012, revealed Diltiazem and Flagyl not documented as given on December 25, 2012 and December 26, 2012, and Lovastatin and Megace not documented as given on December 26, 2012. Medical record review of the resident Progress Notes dated December 25, 2012, revealed " ...Medication no (not) profiled for this pt (patient) in med select ( electronic medication delivery system)...continued review of the December 26, 2012, progress notes revealed " ...med (medication) unavailable..."<br><br>Medical record review of a Physician's telephone order dated January 3, 2013, revealed " ...Talacen 25/650 1 (one) PO (by mouth) q (every) 6 (six) hours PRN (as needed) for pain..." | N 671 | | |

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| N 671 | Continued From page 81<br><br>Interview and computer record review (copy provided) with Medical Assistant #1 and Minimum Data Set (MDS) nurse # 3 on January 23, 2013, at 9:08 a.m., at the 400 hall nurse's station, revealed the Talacen was ordered in the computer on January 3, 2013, at 7:00 p.m.<br><br>Interview and observation on January 23, 2013, at 9:12 a.m., on the 400 hall, with Charge Nurse #4 of the 400 hall medication cart, and review of a Controlled Substance Record revealed the Talacen ordered on January 3, 2013, was not received until January 17, 2013.<br><br>Interview with the facility pharmacy provider by telephone, Pharmacist #1, on February 5, 2013, at 9:22 a.m., confirmed the Talacen was not sent until January 17, 2013.<br><br>Medical record review of a Physician's telephone order dated January 16, 2013, revealed " ...Zosyn (antibiotic)3/375 g (grams) IV (intravenous) Q (every) 6 hours x 7 days..."<br><br>Medical record review of the resident's Medication Administration Record for January 2013, revealed the Zosyn was not started until January 18, 2013, at 12:00 p.m.<br><br>Interview and medical record review with the Director of Nursing (DON) in the DON office on February 5, 2013, at 1:48 p.m., confirmed the medication administration record and the resident progress notes indicated the medications were not administered as ordered by the physician. Continued medical record review and interview confirmed the resident did not receive the Talacen ordered on January 3, 2013, until January 17, 2013, fourteen days after the medication was ordered and the Zosyn ordered | N 671 | | |

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| N 671 | Continued From page 82<br>on January 16, 2013, was not administered until January 18, 2013, two days after the initial order date. The DON stated the nursing staff of the facility were unaware intravenous medications were to be ordered from a different Pharmacy other than the routine Pharmacy used by the facility.<br><br>Resident #38 was admitted to the facility on December 21, 2012, with diagnosis including Severe Sepsis, Urinary Tract Infection, Atrial Fibrillation, and Senile Dementia.<br><br>Medical record review of a Physician's telephone order dated January 3, 2013, revealed " ...Zyvox (antibiotic) 600 mg (milligrams) IV (intravenous) Q 12 Hr (every twelve hours) x (for) 7 days...start Nitrofurantoin (antibiotic)...after completion of Zyvox..."<br><br>Medical record review of the resident's Medication Administration Record (MAR) for January 2013, revealed no documentation of Zyvox or Nitrofurantion administered.<br><br>Interview on February 7, 2013, at 4:30 p.m., with Nurse Practitioner #2 at the 200 hall nurse's station, confirmed the physician wanted the resident to receive the Zyvox, and wanted the resident to receive the Nitrofurantion as a maintenance antibiotic.<br><br>Interview with the Director of Nursing (DON) in the facility conference room on February 8, 2013, at 10:53 a.m., confirmed the facility failed to ensure medications were delivered as ordered.<br><br>Resident #31 was admitted to the facility on November 15, 2012, and discharged on November 16, 2012, with diagnoses including | N 671 | | |

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| N 671 | Continued From page 83<br>Post Cervical Laminectomy Fusion, Depression, and Anxiety.<br><br>Medical record review of an Order Summary Report dated November 15, 2012, through November 16, 2012, revealed "...Percocet Tablet (narcotic pain medication) 10-325 mg (milligram) oral 2 tabs (tablet) q (every) 4 hours prn (as needed)..."<br><br>Medical record review of a Nurse's Progress Note dated November 15, 2012, at 8:21 p.m., revealed "...called on call NP (nurse practitioner)...needing a hard copy for the Tapentadol (narcotic pain medication) 50 mg q 4 hour prn...(no documentation NP returned call)"<br>Interview with LPN #15 who was on duty and assigned to resident #31 on November 16, 2012, on January 30, 2013, at 3:40 p.m., in the West Wing Nurse's Station, revealed the resident requested pain medication on November 16, 2013, at 8:30 a.m., and the Percocet had not been available in the Med Select (medication dispensing system located in the facility) and had not been delivered from the pharmacy until 10:30 a.m.<br><br>Medical record review of a Nurse Progress Note dated November 16, 2012, at 8:38 a.m., revealed " ...med on order ..."<br><br>Medical record review of a Controlled Substance Record dated November 16, 2012, revealed thirty-six Percocet tablets were delivered to the facility on November 16, 2012, (no time) and two tablets were administered to resident #31 on November 16, 2012, at 10:30 a.m.<br><br>Review of facility policy, General Guidelines for Medication Administration, dated 2010, revealed " | N 671 | | |

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| N 671 | Continued From page 84<br>...Medications are administered as prescribed ...if a dose of regularly scheduled medication is withheld ...the reason documented ...if two consecutive doses of a vital medication are withheld ...the physician is notified ..."<br><br>Review of facility policy, Pain Management, dated revised 2010, revealed " ...Purpose ...to provide compassion ...identify residents who has pain symptoms ...through the appropriate pain management techniques ...manage or prevent pain ..."Pain" is an unpleasant sensory and emotional experience ..."<br><br>Interview with Pharmacist #1 on February 5, 2013, at 9:15 a.m., by way of the phone, revealed the facility ordered the Percocet 10-325 mg from the back up pharmacy on November 15, 2012, (controlled substance record dated November 16, 2012, no time). The facility had been a late delivery from the pharmacy occurring after midnight.<br><br>Interview with the Medical Director (MD) on February 13, 2013, at 1:35 p.m., in the Admission Office, revealed the MD had been at the facility on November 16, 2012, had been notified the resident had requested to be discharged, the facility was unable to obtain the resident's narcotic pain medications from the pharmacy and the resident had not been administered pain medications since admission. Continued interview at this time revealed the resident had definitely been experiencing pain during the physician's examination on November 16, 2012; the Director of Nursing (DON) had been present "and cried." Further interview at this time confirmed the facility failed to the resident's narcotic pain medications ordered on November 15 until November 16, 2012. | N 671 | | |

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| N 671 | Continued From page 85<br><br>Resident #2 was admitted to the facility on June 11, 2012, and readmitted to the facility on August 22, 2012, with diagnoses including Decubitus Ulcer, Peripheral Vascular Disease, Cerebral Vascular Disease, Anxiety, and Dementia.<br><br>Medical record review of a Nursing Assessment dated January 13, 2013, revealed the resident was cognitively intact, required extensive assistance with all Activities of Living (ADL's), always incontinent of urine, occasionally incontinent of bowel, and one stage four pressure ulcer.<br><br>Medical record review of a Physician's Telephone Order dated November 20, 2012, revealed " ...Coumadin 6 mg (milligram) ...daily ..."<br><br>Medical record review of a Medication Administration Record dated November 1-30, 2012, revealed no Coumadin administered on November 22-23, 2012.<br><br>Interview with Licensed Practical Nurse (LPN) #1 on January 28, 2013, at 10:45 a.m., in the East Wing Nurse's Station, revealed no Coumadin 6mg had been available from the pharmacy.<br><br>Interview with the Assistant Director of Nursing (ADON) on January 28, 2013, at 3:20 p.m., in the Central Nurse's Station, revealed the facility failed to administer Coumadin for two days to resident #2.<br><br>Resident #50 was admitted to the facility on September 18, 2012, with diagnoses including Chronic Liver Disease, Diabetes, Elevated Ammonia Level, and Toxic Encephalopathy. | N 671 | | |

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| N 671 | Continued From page 86<br><br>Medical record review of a Physician's Telephone Order dated October 16, 2012, revealed " ...KCL (potassium) 20 meq (milliequivalents) PO (by mouth) TID (three daily) today ...give first dose now ..."<br><br>Medical record review of the Medication Administration Record (MAR) dated October 1-31, 2012, revealed the KCL 20 meq had been administered from October 16, 2012, through October 31, 2012 (sixteen days not one day).<br><br>Medical record review of the Medication Administration Record (MAR) dated November 1-30, 2012, revealed the KCL 20 meq had been administered from November 1, 2012, through November 7, 2012 (total of twenty-three days not one day).<br><br>Review of facility policy, General Guidelines for Medication Administration, dated 2010, revealed " ...if there is any reason to question dosage ...the physician's orders are checked for the correct dosage ..."<br><br>Interview with Licensed Practical Nurse (LPN) #22 on January 29, at 7:00 p.m., by telephone, revealed the KCL 20 meq TID had been administered by LPN #22. Continued interview revealed LPN #22 had given the KCL 20 meq from the resident's supply of KCL 30 meq daily (total dose of 90 meq daily).<br><br>Interview with Pharmacist #1 on February 5, 2012, at 9:15 a.m., by telephone, revealed the order for KCL 20 meq tid had been filled on October 29, 2012, as daily (not a one time order), and had transcribed the order wrong.<br><br>Interview with Corporate Nurse #3 on February 8, | N 671 | | |

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| N 671 | Continued From page 87<br><br>2013, at 2:00 p.m., in the Director of Nursing Office, revealed the facility had given the KCL 20 meg daily from October 16, through November 8, 2012, and KCL 30 meq daily. (total dose 90 meq) Continued interview confirmed the facility failed to follow the physician's orders for a significant medication.<br><br>Resident #55 was admitted to the facility on June 7, 2011, and readmitted on March 3, 2012, with diagnoses including Atrial Fibrillation, Alzheimer's Disease, and Urinary Tract Infection.<br><br>Medical record review of a Nursing Assessment dated November 24, 2012, revealed the resident had been cognitively impaired, required extensive assistance in all Activities of Daily Living, supervision for eating, and received anticoagulants.<br><br>Medical record review of the Interdisciplinary Care Plan last updated January 21, 2013, revealed one staff member minimum to extensive assist for transfers, check every thirty minutes, up in wheel chair no longer than one hour at a time, and administer coagulant as ordered.<br><br>Medical record review of the January 2013 Order Summary Report, revealed Coumadin 4.5 mg (milligram) daily.<br><br>Medical record review of a Physician's Telephone Order dated January 4, 2013, revealed change Coumadin to 5 mg daily ..."<br><br>Medical record review of the Medication Administration Record dated January 1-31, 2013, revealed Coumadin 4.5 mg given at 5:00 p.m., Coumadin 5 mg given at 8:00 p.m., and last dose of Coumadin administered January, 24, 2013. | N 671 | | |

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| N 671 | Continued From page 88<br><br>Medical record review of the resident's chart revealed no order to discontinue the Coumadin on January 25, 2013.<br><br>Review of a Medication Error Report dated January 25, 2013, revealed Coumadin 5mg had been discontinued from the medication list on January 25, 2013, without a physician's order.<br><br>Medical record review of a Physician's Telephone Order dated February 1, 2013, revealed Coumadin 5 mg po (by mouth) at Hs (at night). Interview with Licensed Practical Nurse (LPN) #19 on January 30, 2013, at 9:00 a.m., by way of phone, revealed if initialed the MAR for Coumadin the medication had been administered as ordered.<br><br>Interview with LPN #2 on February 7, 2013, at 2:00 p.m., in the Central Nurse's Station, revealed the Coumadin 5mg had been administered as ordered. Continued interview at this time states if it had been given at 5:00 p.m., would not see that on my MAR. Further interview at this time revealed the only medications that viewed would have been for the shift working.<br><br>Interview with Nurse Practitioner (NP) #3 on February 4, 2013, at 1:30 p.m., by way of phone, revealed the Coumadin omission had been discovered by the NP on February 1, 2013.<br><br>Interview with the Assistant Director of Nursing (ADON) on January 3, 2013, at 2:00 p.m., in the ADON office, confirmed the facility had given Coumadin 9.5 mg on January 4, 2013, (Coumadin 5 mg had been ordered) and Coumadin 5 mg had not been administered from January 25-31, 2013, (seven days) and the facility | N 671 | | |

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| N 671 | Continued From page 89<br>failed to follow physician's orders for Coumadin.<br><br>Resident #72 was admitted to the facility on October 19, 2012, with diagnoses including Pneumonia, Urinary Tract Infection, and Chronic Obstructive Pulmonary Disease.<br><br>Medical record review of a Order Summary Report dated December 1-31, 2012, revealed " ...Coumadin 4mg (milligram) once daily ...Start date November 23, 2012 ..."<br><br>Medical record review of a Physician's Telephone order dated December 7, 2012, revealed increase Coumadin 5 mg every night.<br><br>Medical record review of a Medication Administration Record (MAR) dated December 1-31, 2012, revealed the resident received Coumadin 4mg on December 7-8, and on December 9-11, 2012, received no Coumadin. Further review revealed Coumadin 5 mg had been started on December 12, 2013 (five days later and received the wrong dose two days).<br><br>Interview with Licensed Practical Nurse (LPN) #22, on January 23, 2012, by telephone, at 3:10 p.m., revealed the LPN unsure why the wrong dose had been administered.(responsible for medications on December 8, 2012)Continued interview revealed if the Coumadin 4mg had been initialed that had been the dose administered.<br><br>Interview with Licensed Practical Nurse (LPN) #22, on January 23, 2012, by telephone, at #:20 p.m., revealed the LPN unsure why the dose had been omitted.(responsible for medications on December 9, 2012)Continued interview revealed if the Coumadin 5mg had not been initialed the | N 671 | | |

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| N 671 | Continued From page 90<br>LPN had not administered the Coumadin.<br><br>Interview with the Assistant Director of Nursing (ADON) on February 5, 2013, at 10:00 a.m., in the ADON office, confirmed the facility had failed to administer the correct dose of anticoagulants for two days, and failed to administer the anticoagulant for three days. Continued interview revealed the facility failed to follow physician's orders for anticoagulant therapy.<br><br>Resident #35 was admitted to the facility on August 31, 2012, with diagnoses including Pathologic Fracture of Vertebrae, Major Depressive Disorder, Clostridium Difficile (C-Diff), and Urinary Tract Infection.<br><br>Medical record review of a Physician's Telephone Order dated October 12, 2012, revealed " ...Nystatin (antifungal for the mouth) 100,000 u (units) swish and swallow QID (four times a day) ...Dx: (diagnosis) Thrush (yeast infection of the mouth) ..."<br><br>Medical record review of the Medication Administration Record (MAR) dated October 1, 2012, through October 31, 2012, revealed no documentation the resident received the Nystatin as ordered by the physician.<br><br>Review of the pharmacy history revealed no Nystatin had been delivered to the facility and no charges for Nystatin had been recorded for the resident.<br><br>Medical record review of a Physician's Telephone Order dated October 26, 2012, revealed " ...Increase Fentanyl (pain patch - narcotic) 50 mcg Q (every) 72 hours ..." | N 671 | | |

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| N 671 | Continued From page 91<br><br>Medical record review of the MAR dated October 1, 2012, through October 31, 2012, revealed no documentation the resident received Fentanyl 50 mcg until October 31, 2012 (5 days after the order).<br><br>Medical record review of the Physician October Recapitulation Orders dated October 1-31, 2012, revealed " ...Nitro-Dur 0.1 mg/HR (hour) Patch 24 Hour Transdermal daily 0800 For: Angina Pectoris (Angina) (chest pain) ..."<br><br>Medical record review of the October MAR revealed no documentation the Nitro- Dur 0.1 mg/HR Patch for chest pain had been applied on October 21 and 22, 2012.<br><br>Medical record review of the Nurse's Progress Notes dated October 21, 2012, at 9:57 a.m., revealed " ...nitro patch on order ..."<br><br>Medical record review of the Nurse's Progress Notes dated October 22, 2012, at 9:13 a.m., revealed " ...nitro dur on order ..."<br><br>Interview with Licensed Practical Nurse #1 on January 24, 2013, at 3:40 p.m., in the West Wing Nurse's Station, revealed the Nitro-Dur 0.1 mg/HR Patch had not been available from the pharmacy on October 21, and 22, 2012. Further interview at this time revealed the pharmacy had been notified.<br><br>Interview with the ADON on January 23, 2013, at 3:30 p.m. until 4:00 p.m., confirmed the physician ordered the Fentanyl 50 mcg/hr Patch on October 26, 2012, the pharmacy delivered the Fentanyl 50 mcg on October 30, 2012, and the first Fentanyl 50mcg/hr Patch had been administered on October 31, 2012, (five days later). Continued | N 671 | | |

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| N 671 | Continued From page 92<br><br>interview confirmed the resident had not received the pain medication as ordered by the physician. Further interview confirmed the resident had been ordered Nystatin on October 12, 2012, for Dx: of Thrush in the resident's mouth and the Nystatin had not been obtained from the pharmacy and the facility failed to follow the physician's order.<br><br>Resident #28 was admitted to the facility on June 12, 2012, with diagnoses including Atrial Fibrillation, Hypertension, Congestive Heart Failure, Diabetes Mellitus Type 1, Vascular Dementia, Peripheral Vascular Disease, and Atherosleroic (sic) Type Vessel Native/Graft.<br><br>Review of the physician order for resident #28 with order date and start date of October 10, 2012, revealed "...Depakote (Divalproex Sodium) Tablet (medication to prevent seizures) Delayed Release 500 mg (milligrams) oral (by mouth) every HS (bedtime) for 7 days then increase to 500 mg 2 times daily..." Review of the physician order with the start date of October 16, 2012, and the discontinue date of October 17, 2012, revealed " ...Depakote (Divalproex Sodium) Tablet Delayed Release 500 mg oral (by mouth) once daily at HS ..." Review of the physician order with the start date of October 17, 2012, revealed "...Depakote (Divalproex Sodium) Tablet Delayed Release 500 mg oral (by mouth) twice daily..."<br><br>Review of the October 2012, electronic Medication Administration Record (eMAR) revealed "...Depakote (Divalproex Sodium) Tablet Delayed release 500 mg oral every HS for 7 days then increase to 500 mg 2 times daily...start date 10/10/12...D/C (discontinue) date 10/16/12..." Further review revealed no documentation in the administration areas for October 10, 11, 12, 13, | N 671 | | |

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| N 671 | Continued From page 93<br><br>and 14, 2012. Further review of the October 2012, eMAR revealed on October 15, 2012, initials and the number 5 in the administration area. Further review of the eMAR code on the eMAR sheet revealed 5 was Hold/See Nurses Note.<br><br>Review of the nurses progress note dated October 15, 2012, at 21:19 revealed "...Type: eMar (electronic MAR)- Hour of Administration Note: Depakote is listed as "Pending" and none is present on medcart..."<br><br>Review of the nurses progress note dated October 22, 2012 at 21:13 revealed "...Type: eMar - Hour of Administration Note: Depakote not available on medcart for resident. Pharmacy has not made it available..."<br><br>Review of the communication form from the facility to the pharmacy dated October 24, 2012, revealed "...Depakote (Divalproex Sodium) 500 mg Tablet Delayed Release oral (by mouth) twice daily every day:give 1 500 mg tablet 2 times a day with the start date of October 17, 2012..." and no communication form for Depakote administration from October 10 to 17, 2012.<br><br>Review of the October 2012, pharmacy Medical Expenses revealed a new order dated October 24, 2012, for Divalproex 500 mg for 60 tablets for a 30 day supply and no pervious order for Depakote/Divalproex.<br><br>Interview by phone, with Pharmacist #1 on February 5, 2013, at 9:40 a.m., confirmed the pharmacy had not received an order for Depakote one 500 mg tablet for seven days; had not received any order until October 24, 2012, (for Depakote two times a day); had no back-up | N 671 | | |

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| N 671 | Continued From page 94<br>pharmacy charges on record; and Depakote was not available in the med select system.<br><br>Interview with Quality Improvement Coordinator #1 on February 14, 2013, at 7:55 a.m., in the admission office, confirmed the facility generated the eMAR on October 10, 2012, for Depakote. Further interview confirmed the blank administration areas on the eMar dated October 10, 11, 12, 13, and 14, 2012, meant the Depakote was not given or not signed for as administered. Further interview confirmed the pharmacy delivery ticket for Depakote indicated the pharmacy had received the initial Depakote order from the facility on October 24, 2012. Further interview confirmed the Depakote had not been provided by the pharmacy until October 24, 2012., fourteen days after the physician's order to administer the medication.<br><br>Interview with the Corporate Director of Education on February 13, 2013, at 3:50 p.m., in the ADON Office, revealed the facility was currently using the computer software Point Click Care (PCC), this had been new software for this facility, and implemented on October 4, 2012. The Corporate Office provided training to the nurse managers in the facility prior to the software going "live" at the facility. The training had been twenty-one hours, included the whole system, a total of twelve hours training for order entry and E-Mars (electronic MAR). Registered Nurse (RN) #4 (nurse educator for the facility at that time) had been in charge of training the staff at the facility. The Corporate Director of Education had expressed concern, to the Administrator, when the facility had not trained the staff at the facility prior to the facility going "live." The facility staff had not completed the training when the facility went "live." Continued interview at this time revealed no | N 671 | | |

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| N 671 | Continued From page 95<br>problems had been identified at time of implementation, and audits had not been completed for order entry and accuracy of the E-Mars. The Corporate Nurse Educator stated the turnover rate of staff had been very high in this facility; RN #4 had not been able to properly train the staff prior to using the PCC system. Continued interview confirmed staff do not know how to perform their job, and new employees have not been provided training on the PCC system. Further interview confirmed a huge piece of the problem in the facility has been the staff have not been trained or oriented. | N 671 | | |
| N 680 | 1200-8-6-.06(4)(d) Basic Services<br><br>(4) Nursing Services.<br><br>(d) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and certified nurse aides to provide nursing care to all residents as needed. Nursing homes shall provide a minimum of two (2) hours of direct care to each resident every day including 0.4 hours of licensed nursing personnel time. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the availability of a licensed nurse for bedside care of any resident.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, review of facility staffing schedules, review of facility documentation for "Turnover by Facility," observations, and interviews, the facility failed to ensure sufficient staffing to provide shower/baths, incontinent care, repositoning, personal grooming, feeding assistance, medication administration, nursing assessment upon admission or after returning from treatments, and | N 680 | | |

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| N 680 | Continued From page 96<br>properly trained staff administering care for eleven (#5, #8, #9, #15, #20, #29, #31, #53, #54, #40, and #60) of 79 residents reviewed.<br><br>The facility's failure placed the residents in an environment which was detrimental to their health, safety and walfare.<br><br>The findings included:<br><br>Resident #5 was admitted to the facility on May 31, 2012, with diagnoses including Urinary Tract Infection, Bacteremia, Chronic Pain, and Pressure Ulcer.<br><br>Medical record review of a quarterly Minimum Data Set (MDS) dated December 10, 2012, revealed the resident had been cognitively intact for daily decision making and required extensive assistance for all Activities of Daily Living (ADL's).<br><br>Observation and interview with resident #5 on January 17, 2013, at 3:30 p.m., in the resident's room revealed the resident out of bed sitting in a wheelchair, face had a heavy beard growth, and the hair not combed/long. Interview with the resident revealed the resident had not had a shower in three weeks (no documentation of a shower for January). Continued interview revealed the resident would like to have a hair cut.<br><br>Interview with Licensed Practical Nurse (LPN) #6 (Unit Manager) on January 17, 2013, in the resident's room at 3:30 p.m., confirmed the resident's hair is matted, needs a haircut, and a shower. Continued interview confirmed the facility failed to document showers/bed baths for resident #5 and "...the resident needs a shower today." | N 680 | | |

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| N 680 | Continued From page 97<br><br>Resident #8 was admitted to the facility on May 15, 2009, with diagnoses including Senile Dementia, Alzheimer's Disease, and Hypopotassemia.<br><br>Medical record review of the Quarterly assessment dated October 7, 2012, revealed the resident was severely impaired in cognitive skills for daily decision making and was totally dependent with two person physical assistance in bathing.<br><br>Medical record review of the Computerized Activities of Daily Living Flowsheet, dated December 2012 revealed no initials documented on December 3, 2012, for bathing.<br><br>Review of the staffing schedule for 7 a.m. to 7 p.m., dated December 3, 2012, revealed Certified Nursing Assistant (CNA) #13 scheduled for the East Hall.<br><br>Interview on February 7, 2013, at 8:00 a.m., with CNA #13, confirmed, after reviewing the schedule, CNA #13 was the only CNA working on the east hall on December 3, 2012, and was responsible for approximately 20 residents. Continued interview confirmed was not able to get to all the residents timely and a CNA had been pulled from restorative to help with passing (meal) trays.<br><br>Interview on January 29, 2013, at 12:40 p.m., with CNA #1, in the Sanctuary, confirmed the CNA had started cleaning resident #8 on December 24, 2012, had to quit and take care of someone else. Continued interview confirmed the resident's family member had finished the resident's care. Continued interview revealed CNA #1 was the | N 680 | | |

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| N 680 | Continued From page 98<br>only CNA on the hall on December 24, 2012.<br><br>Resident #9 was admitted to the facility on October 23, 2012, with diagnoses including Paraplegia, Diabetes, Cerebrovascular Disease, Depressive Disorder, Rheumatoid Arthritis, Urinary Tract Infection, and Multiple Contractures.<br><br>Medical record review of the Nursing Notes revealed the resident was discharged to the hospital for a psychiatric evaluation on November 28, 2012.<br><br>Medical record review of the admission assessment dated October 30, 2012, revealed the resident scored a fifteen on the BIMS (Brief Interview for Mental Status) assessment indicating the resident was independent with daily decision making Further review of teh MDS revealed the resident was totally dependent with two person assist for bathing.<br><br>Review of facility, Bath and Shower Policy, revealed "Bathe each resident daily, to include a sponge and/or bed bath five times weekly (or more often, if needed) including a tub bath, whirlpool bath or shower at least twice weekly..."<br><br>Review of a Concern Form dated November 12, 2012, revealed "...Resident says...laid in...own waste for 24 hours, until the next shift came in...social worker (SW #1) interviewed resident and offered support/and reassurance."<br><br>Medical record review of the Resident Care flow Sheets dated October 24, 2012 through November 28, 2012, revealed bed baths were documented as given, however, there were no showers or tub baths documented for residnet #9. | N 680 | | |

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| N 680 | Continued From page 99<br><br>Review of facility direct care staffing from November 1-28, 2012, revealed a census between 138-155 and staffing ranging between 2.24-3.54 hours per patient day (PPD).<br><br>Interview on January 28, 2013, at 9:30 a.m., with CNA #3, in the hallway, confirmed CNA #3 was responsible for resident #9's care on November 3, 5, 6, 10, 11, 14, 15, 20, 21, 24, and 25, 2012. Continued interview revealed the resident was paralyzed and required more than one person to transfer the resident from the bed to provide a shower, and and CNA #3 stated the facility did not have enough staff in order to provide a shower to resident #9 on the eleven days described above.<br><br>Interview on January 28, 2013, at 10:00 a.m., with SW #1, in the Social Service office, confirmed the resident had complained of lying in own waste on November 12, 2012. Continued interview confirmed the facility did not have enough staff at the time to provide resident #9 with appropriate care according to the facility's policy.<br><br>Interview on February 7, 2013, at 7:50 a.m., with SW #1, in the Social Services office, revealed the concern expressed by the resident on November 12, 2012, had occurred over a weekend and a new employee was to provide care to the resident and did not know how to change the resident.<br><br>Interview on February 7, 2013, at 8:20 a.m., with the Corporate Quality Improvement Coordinator (QIC #1), in the Admissions office, confirmed the facility experienced staffing shortages during the month of November 2012.<br><br>Resident #15 was admitted to the facility on November 2, 2012, with diagnoses including | N 680 | | |

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| N 680 | Continued From page 100<br>Osteoarthritis, Degenerative Arthritis Left Hip, and left Total Hip Replacement.<br><br>Medical record review of Nursing Notes revealed the resident was discharged home on November 16, 2012.<br><br>Medical record review of the admission assessment dated November 9, 2012, revealed the resident required extensive assistance of one person with bathing.<br><br>Medical record review of the November 2012 Resident Care Flow Sheet, revealed the resident received a bed bath daily from November 3-15, 2012.<br><br>Review of the facility's staffing from November 3, 2012 through November 15, 2012, revealed a census between 140-148, and direct care staffing ranging from 2.40-3.54 hours per patient per day.<br><br>Interview on January 28, 2013, at 9:45 a.m., with the CNA #2 in the hallway, revealed CNA #2 "did the best could, however, some days residents didn't receive scheduled showers due to being short staffed." Continued interview confirmed CNA #2 was responsible for resident #15's care on November 3, 4, 5, 6, 7, 8, and 9, 2012, and confirmed no showers were provided to the resident on the days CNA #2 was responsible for the resident's care.<br><br>Interview on January 28, 2013, at 11:00 a.m., with the Director of Nursing (DON) in the DON's office revealed became the DON the second week of December 2012 and confirmed residents were to receive two showers weekly.<br><br>Resident #20 was admitted to the facility on May | N 680 | | |

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| N 680 | Continued From page 101<br>10, 2012, and readmitted on December 14, 2012, with diagnoses including Altered Mental Status, Status Post Cerebral Vascular Disease, and Deep Vein Thrombus right upper extremity.<br><br>Medical record reivew of an assessment dated November 1, 2012, revealed the resident had short and long term memory problems, had been totally dependent for all ADL's, one stage four pressure ulcer not healed, and received no anticoagulation therapy.<br><br>Medical record review of an Interdisciplinary Care Plan last updated January 28, 2013, revealed required assist of two for transfers, assist of two with all ADL's, and administer anticoagulant as ordered.<br><br>Medical record review of a Nurse Progress Note dated December 15, 2012, 12:04 a.m., revealed the resident was readmitted and the Nurse was instructed by Registered Nurse (RN #4) to pass admission to first shift due to staffing issues.<br><br>Interview with Corporate QIC #1 on February 6, 2013, at 9:40 a.m., in the DON's office confirmed on December 14, 2012, resident #20 had been readmitted to the facility, and documentation by RN #4 revealed due to short staffing the admission (assessment, processing of Physician's orders) had been given to the next shift. Further interview at this time confirmed "if the admission process had not been completed it could have contributed to the resident not receiving medications (antibiotic, pain medication, anticoagulant) on admission."<br><br>Interview with LPN #11 on January 17, 2013, at 10:00 a.m., in the Central Nurse's Station, confirmed showers had not been given as | N 680 | | |

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| N 680 | Continued From page 102 | N 680 | | |

needed. Continued interview revealed the CNA's have twenty-five residents most days.

Interview with the Administrator on January 28, 2013, at 3:00 p.m., in the Administrator's Office, revealed the facility had designated RN #4 as the Nurse Educator since hire. Continued interview revealed RN #4 had not been able to focus on education due to the RN had to serve in other various Key positions in the facility. Further interview confirmed the facility had not completed licensed nurse competencies, and "education had been severely neglected in this facility for a long time."

Interview with LPN #2 on February 4, 2013, at 9:40 a.m., in the East Hallway, confirmed on February 2, 2013, the East Wing in the facility had thirty-nine residents with one LPN and two CNA's. Continued Interview confirmed the staff had not been able to administer medications timely, feed the residents, provide baths (showers/bed baths), and/or provide incontinence care.

Interview with RN #4 on February 8, 2013, at 7:05 a.m., by telephone, revealed the RN had been the Nurse Educator at the facility since April 2012. Continued interview revealed the RN was unable to do in-services due to staffing issues. Further interview revealed RN #4 had served as the Director of Nursing on two separate occasions, trainer for the Point Click Care (computer soft ware), worked the floor on a cart (when facility was short staffed), and was currently the Night Shift Supervisor.

Resident #29 was admitted to the facility on September 19, 2009, with diagnoses including Altered Mental Status, Senile Dementia, Senile

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| N 680 | Continued From page 103<br>Dementia with Delusional Features, Meniere's Disease, and Chronic Peptic Ulcer.<br><br>Medical record review of the Annual Assessment dated September 12, 2012, and the Quarterly MDS dated December 16, 2012, revealed the resident was cognitively impaired and totally dependent on one person physical assistance for ambulation, dressing, and eating.<br><br>Review of the January 2013 Order Summary Report, revealed a Physician Order dated January 21, 2013, to start January 22, 2013, for Vancomycin HCL (antibiotic) in Dextrose Solution 1 GM/200 ML (1 Gram per 200 Milliliters) Use 1 gram intravenously two times a day for infection until 02/04/13 23:59 (11:59 p.m.)Vancomycin 1 gram/200 ml at 125 mg/hr every 12 hours.<br><br>Observation on January 29, 2013, at 10:50 a.m., in the room of resident #29, revealed LPN #5 setting the IV (intravenous) antibiotic therapy pump (IV pump).<br><br>Interview on January 29, 2013, at 10:50 a.m., with LPN #5, at the IV pump for resident #29, revealed LPN #5 had "...asked several times for IV training and not received any yet and I'm not sure how to operate the pump..."<br><br>Review of the Education Roster dated January 30, 2013, revealed an in-service for IV Pump Vista Basic Instructions and Return Demonstration. Further review revealed LPN #5 was not listed as attending the January 30, 2013, in-service for IV Pump Vista Basic Instructions and Return Demonstration.<br><br>Review of the resident meal hours posted | N 680 | | |

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| N 680 | Continued From page 104<br><br>effective October 15, 2012, revealed east hall receives Breakfast trays at 8:15 a.m.; Lunch trays at 12:45 p.m.; and Dinner trays at 6:15 p.m.<br><br>Interview on January 30, 2013, at 8:50 a.m., on the East Wing hall with CNA #9, revealed CNA #9 was on duty for Dinner trays the previous day and stated "...was confused last night regarding who to feed...finished feeding at 7:15 p.m. last night...unable to feed resident #29...told both nurses...unsure if they (nurses) fed (resident #29)..."<br><br>Interview on January 30, 2013, at 9:00 a.m., at the East Wing nursing station, with LPN #21 assigned to resident #29 last night, confirmed "...I did not feed (resident #29) last night..."<br><br>Resident #31 was admitted to the facility on November 15, 2012, and discharged on November 16, 2012, with diagnoses including Post Cervical Laminectomy Fusion, Depression, and Anxiety.<br><br>Medical record review of a Nurse Progress Note dated November 16, 2012, revealed "...family...concerned about lack of nursing staff to check on pt (patient)..."<br><br>Interview with LPN #10 on February 8, 2013, at 10:00 a.m., in the conference room, confirmed on November 15, 2012, the family had been upset due to the facility had not provided the resident's pain medication timely (nurse had not faxed to pharmacy) and the LPN had not been able to do the admission assessment due to 1 LPN on duty for a thirty-seven bed unit.<br><br>Interview with the Medical Director (MD) on February 13, at 1:30 p.m., in the Admission | N 680 | | |

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| N 680 | Continued From page 105<br><br>Office, confirmed the facility had failed to provide sufficient staff to obtain the resident's pain medications. Continued interview confirmed the MD had instructed the Administrator "take care of the issue this can't happen again."<br><br>Resident #53 was admitted to the facility on October 11, 2010, and readmitted on January 19, 2013, with diagnoses including Late Effect Hemiplegia Dominant Side Right, Dialysis, and Peripheral Vascular Disease.<br><br>Medical record review of the quarterly assessment dated January 11, 2013, revealed the resident was moderately impaired for daily decision making, required extensive assistance for ADL's, and received Dialysis services.<br><br>Medical record review of the Interdisciplinary Care Plan dated January 28, 2013, revealed no care plan for the days/times for dialysis, mode of transportation, and monitoring of the dialysis shunt pre and post dialysis.<br><br>Interview with LPN #4, on February 4, 2013, at 1:25 p.m., in the North Hall, revealed LPN #4 had been unsure of Resident #53's dialysis schedule, and there was no documentation the dialysis catheter had been assessed after returning from dialysis. Continued interview at this time revealed LPN #4 had worked as a dialysis nurse in the past, the assessment of the dialysis catheter was not on the MAR (Medication Administration Record), and the LPN did not have time to check the catheter due to LPN #4 had over twenty five resident's "to pass medications for the 7a- 7p shift, checkd blood sugars, assist feeding, charting, and any problems that occur."<br><br>Resident #54 was admitted to the facility on | N 680 | | |

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| N 680 | Continued From page 106<br><br>December 20, 2012, with diagnoses including Stage IV Small Lung Cancer with Extensive Bone Metastases, Septic Shock, Urinary Tract Infection, and Osteoarthritis.<br><br>Medical record review of the admission assessment dated December 27, 2012, revealed the resident scored fourteen on the BIMS indicating the resident was independent with daily decision making skills, required extensive assistance with hygiene needs, and was frequently incontinent of bowel.<br><br>Observation and interview with the resident on January 16, 2013, at 10:00 p.m., revealed the resident lying on the bed and stated had a soiled incontinent brief and had asked for help one to two hours ago. Continued interview revealed the resident had told a CNA the resident's bowels had leaked and the CNA had turned off the resident's call light, and the told resident #54 the brief wasn't soiled. Continued interview revealed the resident's daughter usually came to the facility nightly to ensure the resident was cleaned at bedtime and couldn't come tonight due to the weather.<br><br>Observation on January 16, 2013, at 10:05 p.m., revealed CNA #12 answered the resident's call light and provided incontinence care to the resident. Continued observation revealed when CNA #12 removed the resident's brief dried fecal matter was on the resident's groin and on the buttocks. Continued observation revealed CNA #12 wiped several times applying pressure to remove the dried fecal matter.<br><br>Review of the facility direct care staffing for January 16, 2013, revealed a census of 122, and staffing of 3.21 hours per patient day. | N 680 | | |

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| N 680 | Continued From page 107<br><br>Interview on January 16, 2013 at 11:00 p.m., with CNA #12 revealed the CNA was responsible for the resident's care. Continued interview revealed the CNA had reported for work on January 16, 2013, at 7:00 p.m., and confirmed had not checked on resident #54 since arriving at the facility. Continued interview confirmed the resident had dried fecal matter on the buttocks and groin and CNA #12 stated the facility was "short staffed."<br><br>Interview on February 7, 2013, at 9:15 a.m., with the DON in the MDS office revealed all residents were to be checked when the CNAs began their shift. Continued interview revealed resident #54's need for incontinence care was not met.<br><br>Resident #40 was admitted to the facility on October 9, 2012, with diagnoses including Metastatic Prostate Cancer, Asthma, Congestive Heart Failure, and Hypertension.<br><br>Medical record review of the Nursing Notes revealed the resident expired on January 11, 2013.<br><br>Review of a Concern Form dated November 10, 2012, revealed "...family member found (resident)...sitting in...own waste for a period of time, bed pad was nasty, room was nasty...social services will notify DON and will address situation...social services contacted both departments housekeeping and attending nurse/DON about the concerns. Both parties agreed to take care of the situation. Room will be cleaned & techs will change resident..."<br><br>Review of the facility direct care staffing for | N 680 | | |

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| N 680 | Continued From page 108<br>November 10, 2012, revealed a census of 146, and staffing of 2.40 hours per patient per day.<br><br>Interview on February 7, 2013, at 7:50 a.m., with SW #1, in the Social Services office, confirmed the resident's family member had voiced a concern on November 10, 2012. Continued interview revealed the family member had noted the bed pad was soiled and the floor was nasty.<br><br>Interview on February 7, 2013, at 8:20 a.m., with QIC #1 confirmed the facility had staffing difficulties during November 2012.<br><br>Interview on January 31, 2013, at 7:45 a.m., with LPN #28, in the conference room, revealed on the 7:00 p.m., until 7:00 a.m., shift January 30-31, 2013, LPN #28 was the only nurse for the West Wing (a 51 bed skilled unit/wing) with one CNA. Continued interview revealed LPN #28 felt the residents were neglected, showers were not given, and the residents were not checked on at least every two hours. Continued interview revealed two residents had died during the night and LPN #28 did not have time to process new Physician Orders.<br><br>Review of the Nursing Assignment Sheet dated January 30, 2012, confirmed there was only one LPN on the skilled unit from January 30-31, 2013, 7:00 p.m., until 7:00 a.m.<br><br>Resident #60 was admitted to the facility on August 6, 2010, with diagnoses including Legal Blindness, Diabetes, and Lower Limb Amputee.<br><br>Medical record review of a quarterly assessment dated January 4, 2013, revealed the resident had been cognitively intact for daily decision making and required extensive assistance with all ADL's. | N 680 | | |

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| N 680 | Continued From page 109<br><br>Observation and interview with resident #60 on January 30, 2013, at 10:45 a.m., revealed the resident lying on the bed and stated the staff had not been giving the resident showers but had been given bed baths for the month of December.<br><br>Interview with CNA #1 on January 29, 2013, at 12:40 p.m., in the Sanctuary, revealed CNA #1 "unable to give showers due to short of help in December." Continued interview revealed when the CNA first started in October 2012 no shower list had been available and stated "Showers had been given when the CNA decided they needed a shower." Further interview revealed the resident had not received any showers for the month of December but received bed baths almost daily.<br><br>Review of facility document, "Turnover by Facility - February 2012 through January 2013, revealed in September 2012 there were 11 terminations; the average number of employees was 118; the percentage of turnover was 9.32%; and the annualized turnover was 168.04%.<br><br>Further review revealed in October 2012 there were 14 terminations; the average number of employees was 117; the percentage of turnover was 11.97%; and the annualized turnover was 161.28%.<br><br>Further review revealed in November 2012 there were 16 terminations; the average number of employees was 118; the percentage of turnover was 13.56%; the annualized turnover was 168.05%.<br><br>Further review revealed in December 2012 there were 9 terminations; the average number of employees was 127; the percentage of turnover | N 680 | | |

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| N 680 | Continued From page 110<br>was 7.09%; and the annualized turnover was 154.35%.<br><br>Further review revealed in January 2013 there were 19 terminations; the average number of employees was 130; the percentage of turnover was 14.62%; and the annualized turnover was 146.64%<br><br>Review of facility staffing dated January 14, 2013, revealed on the 7:00 p.m. - 7:00 a.m. shift there were three LPNs from 10:40 p.m. through 7:00 a.m., for a census of 124 residents on four units. One of the LPNs was restricted to light duty.<br><br>Review of facility staffing dated January 26, 2013, revealed no direct care RN was scheduled.<br><br>Interview with the Administrator on January 29, 2013, at 8:00 a.m., in the Administrator's office, confirmed "...there weren't any (RNs scheduled)...there were no RNs in the building for January 26, 2013..."<br><br>Review of the Nursing Home Licensure Checklist for Staffing Requirements, from November 1, 2013 through January 27, 2013, revealed no direct care RN was in the facility on November 17, and 18, 2013; December 1, 23, 29, and 30, 2013; and January 13, and 26, 2013.<br><br>Interview with the Administrator, with the DON present, on February 4, 2013, at 10:45 a.m., in the Administrator's office, confirmed awareness of no direct care RN was scheduled on November 17, and 18, 2012; December 1, 23, 29, and 30, 2012; and January 13, and 26, 2013. Further interview revealed RN #5 was terminated on November 14, 2012. Further interview revealed RN #4 was changed from the Staff | N 680 | | |

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| N 680 | Continued From page 111<br><br>Development position to an evening RN supervisor position on January 13, 2013. Further interview confirmed the Administrator was going to cover the unscheduled RN time slots by having RN #4 on call (available by telephone) but not physically present in the facility. Further interview with the Administrator confirmed the Administrator was aware the facility was not in compliance with the RN hours.<br><br>Review of the Time Card Report for November 11 to 19, 2012, revealed RN #5 was on paid leave for that period.<br><br>Review of the facility staffing dated December 31, 2012, revealed two of the four CNAs scheduled and three of the four LPNs scheduled reported to work for the 7:00 p.m. to 7:00 a.m. shift. Further review revealed there were two CNAs in the facility from 10:30 p.m. to complete the shift at 7:00 a.m. for 140 residents.<br><br>Interview on February 14, 2013, with the Corporate Director of Operations, in the admissions office, revealed the Director of Operations was aware of staffing issues at the facility. Continued interview revealed there had been a long history of staffing problems including staff retention. Continued interview revealed there had been several changes of Administrators at the facility trying to make a culture where people would want to work. | N 680 | | |
| N 691 | 1200-8-6-.06(4)(o) Basic Services<br><br>(4) Nursing Services.<br><br>(o) Body position of residents in bed or chair bound shall be changed at least every two (2) hours, day and night, while maintaining good | N 691 | | |

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| N 691 | Continued From page 112<br>body alignment. Proper skin care shall be provided for bony prominences and weight bearing parts to prevent discomfort and the development of pressure areas, unless contraindicated by physician ' s orders.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility investigation review, facility policy review, observations, and interviews the facility failed to provide the necessary care to prevent an avoidable pressure ulcer from developing for one resident (#33) and delayed in providing treatment to three residents (#'s 12, 6, 10) admitted with pressure sores of seven residents reviewed with pressure sores from a total sample of seventy-nine.<br><br>The facility's failure resulted in resident #33 developing an unstageable pressure ulcer with black eschar to the back of the right leg requiring surgery for a tendon resection resulting in right foot drop, the facility's failure resulted in resident #2 developing a Stage III pressure ulcer to the right heel and the worsening of a coccyx and mid spine pressure ulcer related to staff not providing timely incontinence care and frequent turning and repositioning, the facility's failure to provide timely assessments and treatments also resulted in the further breakdown of pressure sores for resident #'s 12, 6, and 10, and placed the residents in an environemnt which was detrimental to their health, safety, and welfare.<br><br>The findings included:<br><br>Review of the facility's Wound Documentation Progress Tracking Report under Purpose revealed, "It is the policy of this facility to monitor the progress of each individual wound and | N 691 | | |

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| N 691 | Continued From page 113<br>provide information to the interdisciplinary team to assist in determining the most appropriate modalities." Review of the facility's Wound Documentation Progress Tracking Report under Procedure 4. "Aggessive wound management with eventual plan of healing."<br><br>Resident #33 was admitted from the hospital to the facility on July 20, 2012 with diagnoses including Status Post Right Distal Leg fracture of the Fibula and possibly Tibial Metastasis, Coronary Artery Disease, Cerebrovascular Disease, Moderate to Severe Dementia and Type 2 Diabetes Mellitus.<br><br>Medical record review of a hospital Consultation note dated July 16, 2012, revealed "...Imaging Procedure...views of the right knee obtained. These show comminuted fracture of the proximal tibia with minimal displacement...Impression...Fibular and tibial proximal fracture...Recommendations...The patient will be placed in a knee immobilizer...will be partial weight bearing...will plan for nonsurgical treatment..."<br><br>Medical record review of the facility Admission Skin Assessment dated July 20, 2012, revealed, "...Has no skin problems or lesions present..."<br><br>Medical record review of the admission Nursing Assessment dated July 27, 2012, revealed, "...Skin Conditions...Is the resident at risk of developing pressure ulcers?...yes...Number of stage 3 pressure ulcers?...0...Number of stage 4 pressure ulcers?...0...Number of unstageable pressure ulcers?...0<br><br>Medical record review of a facility History and Physical completed on July 24, 2012, after | N 691 | | |

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| N 691 | Continued From page 114<br><br>admission revealed "...Patient had a fall and fractured...right fibula and tibia...They opted for nonsurgical repair and treated...with a leg immobilizer...Family History...Significant for diabetes...Review of Systems...mentions some leg pain...Physical Examination...Right leg has brace on it..."<br><br>Medical record review of an Occupational Therapist (OT) note dated August 7, 2012, at 4:27 p.m., revealed, "...daughter present during treatment session this date...During tx (treatment) session open area noted on back of R (right) leg this date...notified nursing staff..."<br><br>Interview on February 13, 2013, at 10:15 a.m., in the facility conference room, with the Occupational Therapist Assistant (OTA) #1 who discovered the wound, revealed the OTA would not typically remove brace, "Physical Therapy would usually work more with the lower extremities."<br><br>Medical record review of Physical Therapy (PT) notes dated July 26, 2012, revealed "...R (right) unable to test secondary to leg brace and pain level...Pt (patient) moans with any movement of R (right) leg, even while in brace...Tolerated gentle R (right) hip and ankle ROM (range of motion), but said it hurt. Pt wore immobilizer..." July 27, 2012, "...Pt said her LE (lower extremity) at pain level 10 of 10..." July 30, 2012, "...Reported pain in R leg 10/10..."July 31, 2012, "...c/o (complained of) pain in RLE..." August 1, 2012, "...Daughter at care plan meeting. Pain medications increased..."August 2, 2012, "...RLE (right lower extremity) unable to test secondary to leg brace and pain level.." August 3, 2012, "...said...leg continues to hurt but not as much as it did..." August 6, 2012, "...Pain in R LE, especially when | N 691 | | |

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| N 691 | Continued From page 115<br>lowering leg in immobilizer..."<br><br>Interview and review of the physical therapy notes, with Physical Therapy Assistant (PTA) #1 on February 13, 2013, at 3:22 p.m., confirmed the resident did complain of pain to the lower extremity, and the PTA did not assess the back of leg when the brace straps were loosened during treatment.<br><br>Medical record review of a Nurse Practitioner (NP) progress note dated August 7, 2012, revealed, "...newly discovered wound on the posterior right aspect of the patient's right leg...There is a wound to the posterior right aspect of the right ankle. There is some black eschar centrally located...There is an odor present...We will consult orthopedics for a new immobilizer and/or alternate treatment as this (current) immobilizer is unable to be reapplied..."<br><br>Medical record review of a Physician progress note dated August 8, 2012, revealed, "...There is an unstageable wound with black eschar on the dorsum of the right ankle with some foul odor and slight purulence..."<br><br>Review of the facility investigation dated August 7, 2012, revealed, "...Pressure on Achilles (tendon at back of ankle)...getting bathed when area noted...possible cause...pressure from leg brace...no current order for skin protectants. Resident had immobilizing brace on due to fx (fracture) tib/fib (tibia and fibula)...Stage 3 at Achilles...cause...friction from brace which extended to ankle...Could it have been prevented?...Yes, when brace removed, entire leg should have been assessed for friction areas. Orders should have been obtained on admission regarding removal of brace for skin assessment | N 691 | | |

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| N 691 | Continued From page 116<br>and cleaning..."<br><br>Medical record review of a physician's Telephone Order dated August 22, 2012, revealed, "...refer to...wound center..." Continued review of a wound center progress note dated October 30, 2012, revealed, "...F/U (follow-up) right heel wound seen at wound center...required excision tendon...tendon resected..."<br><br>Interview with Licensed Practical Nurse (LPN) #12 on January 22, 2013, at 9:40 a.m., on the 300 hallway revealed "...have not always had treatment nurses only since October...not always lucky enough to have wound care...if have extra person they do wound care..."<br><br>Observation of the resident in the resident's room on January 24, 2013, at 9:45 a.m., with the Wound Care Nurse, revealed a closed area of dry pink skin at the right Achilles. Continued observation revealed the right foot to be extended downward with foot drop.<br><br>Interview with the Director of Nursing (DON) in the DON office on January 30, 2013, at 8:12 a.m., confirmed the right leg immobilizer was not released and the skin under the brace observed for pressure areas from the resident's admission on July 20, until August 7, 2012, resulting in the development of an avoidable, unstageable pressure sore requiring surgical intervention.<br><br>Interview with the Medical Director on January 30, 2013, at 11:15 a.m., in the conference room, confirmed the pressure area could have been prevented and it should have been assessed prior to the discovery on August 7, 2012.<br><br>Resident #2 was admitted to the facility on June | N 691 | | |

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| N 691 | Continued From page 117<br>11, 2012, and readmitted on August 22, 2012, with diagnoses including Decubitis Ulcer, Peripheral Vascular Disease, Anxiety and Dementia.<br><br>Medical record review of the Admission Skin Assessment dated August 22, 2012, revealed, "...Area 1: coccyx...pressure ulcer Stg (stage) 4...length: 3.5 (centimeters {cm})...width: 2.5 (cm) depth: 1.9 (cm)...Pressure score risk assessment...Total Score: 13...Risk Category: Pressure Sore, High Risk..."<br><br>Medical record review of the Skin/Wound Tx (treatment) dated August 1-31, 2012, revealed August 23-31, 2012, cleanse open area to coccyx with NS (normal saline), pat dry, pack wound with gauze soaked in NS, cover with Allevyn dressing daily AM (morning)..."<br><br>Medical record review of the Weekly Body Audit dated August 29, 2012, revealed "...no foot problems..."<br><br>Medical record review of a Nurse Progress Note dated August 31, 2012, revealed during a dressing change the dressings were soiled.<br><br>Medical record review of a Nurse Progress Note dated September 27, 2012, revealed, "...Assessment type: Initial assessment 9/26/12...Area: mid spine...Onset/Discovery Date: 09/26/12...area 2.25 (cm)...width: 1 (cm)..."<br><br>Medical record review of the Skin/Wound Tx dated September 1-30, 2012, revealed, "...cleanse area at mid spine with wound cleanser, apply Allevyn, and change every three days..." | N 691 | | |

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| N 691 | Continued From page 118<br><br>Medical record review of the Weekly Skin Audit dated September 28, 2012, revealed, "...Area 1: coccyx...Description: tenderness present...length: 3.1 (cm)...width: 3.3 (cm) depth: 1 (cm)...undermining...exposed palpable bone..." Continued review of the Weekly Skin Audit dated September 28, 2012, revealed no description or measurements of the mid spine area.<br><br>Medical record review of the Treatment Administration Record (TAR) dated October 1-31, 2012, revealed no documentation the mid spine dressing had been changed every three days as ordered on October 3, 6, 11, 23, 26, and 29, 2012.<br><br>Medical record review of a Physician's order dated October 5, 2012, revealed, "...alternating pressure relief mattress...limit w/c (wheelchair) time to 1-2 hours max (maximum) every shift...every day..."<br><br>Medical record review of a nurse's Progress Note dated October 6, 2012, at 3:48 a.m., revealed, "...peri-wound area is quite red and extending along upper margins...time in wheelchair be limited to...(less than)...2 hours at one time...need for perineal/incontinence care be evaluated hourly...patient to be assisted to turn q (every) 2 hours..."<br><br>Medical record review of a nurse's Progress Note dated October 6, 2012, at 11:58 a.m., revealed, "...Dressing not done per wound care nurse..."<br><br>Medical record review of a Physician's Telephone Order dated October 7, 2012, revealed, "...D/C (discontinue) previous wd (wound) care orders, cleanse with NS or wd cleanser place medihoney to fit wound bed cover with absorptive | N 691 | | |

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| N 691 | Continued From page 119<br>dressing...abd (abdominal pad-used for absorption) calcium alginate and/or 4X4s (four inch by four inch gauze pads) secure with protective dressing..."<br><br>Medical record review revealed no documentation of any assessment of the resident's feet (skin assessment) from August 29, until October 8, 2012, when a nurse's progress note dated October 8, 2012 at 06:02 a.m., revealed, "...purple colored area on right heel...no open area noted..."<br><br>Medical record review of a nurse's Progress Note dated October 8, 2012, at 3:04 p.m., revealed, "...assessment of bilateral heels performed by wound care team...prep applied to heels and inflatable boots applied..."<br><br>Medical record review of a Weekly Summary dated October 9, 2012, revealed, "...Site...coccyx...Type...pressure...Length: 3.5 (cm)...Width: 3.7 (cm)...Depth: 1 (cm)...Stage IV (four)...<br>Site...right heel...Type...pressure...Length: 1.8 (cm)...Width: 3.7 (cm)...Depth: 0 (cm)...Stage...Suspected Deep Tissue Injury...<br>Site...left heel...Type...pressure...Length: 1.4 (cm)...Width: 0.8 (cm)...Depth: 0 (cm)...Stage...Suspected Deep Tissue Injury..."<br>Continued review of the Weekly Summary revealed no documentation of the mid spine area.<br><br>Medical record review of a nurse's progress note dated October 20, 2012, revealed, "Bilateral heels with stage 1 pu (pressure ulcer)...see measurements wound nurse for coccyx and treatment..." Continued medical record review revealed no measurements located for this date. | N 691 | | |

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| N 691 | Continued From page 120<br><br>Medical record review of a nurse's Progress Note dated October 25, 2012, revealed, "...Air mattress not on...discovered one of hoses disconnected..."<br><br>Medical record review of a nurse's Progress Note dated October 28, 2012, revealed, "...Eschar (dead skin) covered area at right heel...heel painful to touch..."<br><br>Medical record review of a nurse's Progress Note dated November 8, 2012, revealed, "...Dressing to spine replaced...area a little redder today..."<br><br>Medical record review of a nurse's Progress Note dated November 9, 2012, revealed, "...complaining that heels hurt more today..."<br><br>Medical record review of a Physician's Telephone Order dated November 19, 2012, revealed, "...Area at mid spine with stage 2 PU (pressure ulcer) over boney prominence has extensive discoloration of skin surrounding pressure ulcer; assist this patient with repositioning off of back every two hours..."<br><br>Medical record review of a nurse's Progress Note dated November 26, 2012, at 6:47 a.m., revealed, "...bed saturated x's 2..."<br><br>Medical record review of a Weekly Summary dated November 26, 2012, at 8:27 a.m., revealed, "Site...coccyx...Type...pressure...Length: 3.2 (cm)...Width: 3.2 (cm)...Depth: 1.2 (cm)...Stage IV...<br>Site...right heel...Type...pressure...Length: 0.2 (cm)...Width: 0.2 (cm)...Depth: 0.1 (cm)...Stage III (three)...<br>Site...Mid spine...Type...pressure...Length: 0.8 (cm)...Width: 0.8 (cm)...Depth: 0.1 (cm)...Stage II (two) | N 691 | | |

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| N 691 | Continued From page 121<br><br>Medical record review of a Weekly Summary dated December 29, 2012, revealed, "...Site...coccyx...Type...pressure...Length: 3.5 (cm)...Width: 3.0 (cm)...Depth: 0.3 (cm)...Stage IV...Details/Comments...Mid spine and heels are resolved...assure shearing does not occur..."<br><br>Medical record review of a Weekly Summary dated January 8, 2013, revealed, "...Details/Comments...recent Foley removal (catheter in bladder to drain urine into a drainage bag)...resident is incontinent..."<br><br>Medical record review of a nurse's Progress Note dated January 9, 2013, revealed, "...undermining to wound is returning and pressure around peri wound is noted...spoke with tech (Certified Nurse Aide) in charge of this resident to encourage and remind resident is to stay off back..."<br><br>Medical record review of a Nursing Assessment dated January 13, 2013, revealed the resident was cognitively intact, required extensive assistance with all Activities of Daily Living (ADLs), always was incontinent of urine, occasionally incontinent of bowel, and had one stage four pressure ulcer.<br><br>Medical record review of the Care Plan dated January 23, 2013, revealed "...assist resident to turn every two hours, assist to toilet every two hours...coccyx open area...keep off back as much as possible..."<br><br>Observation on January 28, 2013, at 9:00 a.m., 10:00 a.m., and 11:00 a.m., in the resident's room, revealed the resident lying on the back on the bed. | N 691 | | |

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| N 691 | Continued From page 122<br><br>Interview with CNA #6 on January 28, 2013, at 11:00 a.m., in the split hallway, revealed CNA #6 was "assigned to care for (Resident #2) today." Continued interview confirmed CNA #6 had been on duty since 7:00 a.m., and had not been in resident #2's room yet today. CNA #6 stated was unsure if the resident was continent or incontinent (of bowel and bladder).<br><br>Interview with CNA #4 on January 28, 2012, at 11:05 a.m., in the 100 hallway, revealed the CNA had not provided any care for resident #2 today.<br><br>Interview with CNA #7 on January 28, 2012, at 11:06 a.m., in the 100 hallway, revealed the CNA had assisted Licensed Practical Nurse (LPN) #3 today to turn the resident on the side in order for LPN #3 to administer an injection, and had not checked resident #2 for incontinence.<br><br>Interview with LPN #3 on January 28, 2012, at 11:07 a.m., in the 100 hallway, revealed LPN #3 had just given resident #2 an injection and the resident had not been checked for incontinence.<br><br>Observation and interview with the Director of Nursing (DON) on January 28, 2013, at 11:15 a.m., in the resident's room, revealed the CNA Assignment Care Card was to be placed in the resident's closet door, and confirmed no CNA Assignment Care Card for resident #2 was present on the closet door.<br><br>Observation on January 28, 2013, at 11:30 a.m., in the resident's room, revealed Certified Nurse Aide (CNA) #4 checked the resident's incontinence brief and stated "the line on the diaper was yellow that meant the resident is dry", and covered the resident with the bed covers. During continued observation at this time the | N 691 | | |

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| N 691 | Continued From page 123<br><br>surveyor requested to view the resident's skin. The CNA removed the resident's brief and revealed a moderate amount of stool present in the brief and a dressing to the coccyx.<br><br>Interview with the resident on January 28, 2012, at 11:40 a.m., in the resident's room, revealed the resident had not known had been soiled and the resident stated it made the resident feel uncomfortable.<br><br>Observation on January 30, 2013, at 7:30 a.m., in the resident's room, with the wound care nurse, revealed the resident lying on the back. Continued observation revealed the resident stated to the wound care nurse "I'm wet". A strong odor of urine was present in the resident's room. Continued observation revealed at 7:35 a.m., LPN #24 assisted the resident to turn to the left side and removed the bed covers. Continued observation revealed dark brown rings were present on the sheet and incontinence pad the resident was lying on, the resident's gown was wet with brown discoloration. Continued observation revealed when the resident's adult brief was removed the resident and brief were saturated with urine and feces.<br><br>Observation and interview with the DON on January 30, 2012, at 7:40 a.m., in the resident's room, confirmed there were dark brown rings on the resident's sheet and mattress pad, the resident's gown was wet with brown discoloration, and the DON stated, "The diaper can't hold anymore".<br><br>Interview with LPN #24 on January 30, 2013, at 8:10 a.m., in the resident's room, confirmed the dressing (covering the stage four pressure ulcer) was saturated with urine and feces, there was | N 691 | | |

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| N 691 | Continued From page 124<br>redness around the peri area of the pressure ulcer, and the boney prominence at mid spine was reddened.<br><br>Interview with the Medical Director on January 30, 2013, at 11:00 a.m., in the Conference Room, confirmed if a resident is not turned at least every two hours, and has been left soiled in urine and/or feces this will contribute to a resident developing pressure ulcers and pressure ulcers not healing properly.<br><br>Resident #6 was admitted to the facility on October 2, 2012, with diagnoses including Legally Blind, Healing Sacral Decubiti, Ulcer, Pain, Dysphagia, and Urinary Tract Infection.<br><br>Medical record review of a Nursing Assessment dated October 9, 2012, revealed the resident was cognitively intact, experienced limited vision, required extensive assistance with all Activities of Daily Living, experienced pain frequently, feeding tube for nutrition, at risk of developing pressure ulcers, and oxygen had been used while a resident at the facility.<br><br>Medical record review of the Admission History and Physical dated October 2, 2012, revealed " ...Assessment: Healing sacral decubiti ...(no measurements)"<br><br>Medical record review of the admission skin assessment dated October 2, 2012, at 5:56 p.m., revealed " ...sacrum coccyx ...(no additional information)"<br><br>Medical record review of the pressure sore risk admission assessment dated October 2, 2012, at 9:58 p.m., revealed a total score of fifteen with a | N 691 | | |

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| N 691 | Continued From page 125<br>score of eight or above being at high risk for pressure sores.<br><br>Medical record review of the October 2012, physician Order Summary Report revealed " ...cleanse sacral PU (pressure ulcer) with wd (wound) cleanser, pat dry, skin prep and apply hydrocolloid ...change q (every) 3 days ...Start Date 10/06/2012 ..."<br><br>Medical record review of the Treatment Administration Record (TAR) dated October 1-31, 2012, revealed the first treatment to the PU had been October 6, 2012. The pressure ulcer was identified on admission on October 2, 2012.<br><br>Medical record review of October 2012, Order Summary Report revealed " ...Cleanse Stage II pressure ulcer with wound cleanser cover with duoderm every 2 days ...Start Date 10/07/2012 ..."<br><br>Medical record review of the Interdisciplinary Care Plan dated October 16, 2012, revealed " ...Impaired skin integrity ...existing stage 2 area on coccyx ...Goal no further skin impairments ...weekly skin audits ..."<br><br>Medical record review of a skin assessment dated October 16, 2012, revealed " ...stage 2 area on coccyx ..."<br><br>Medical record review revealed the resident discharged from the facility on November 6, 2012.<br><br>Interview with the Director of Nursing (DON) on January 30, 2013, at 1:20 p.m., in the DON office, revealed the resident was admitted on October 2, 2012, with a Stage I Healing Sacral Decbitus, no measurements of the wound had been | N 691 | | |

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| N 691 | Continued From page 126<br>documented, and no treatments had been initiated until October 6, 2012, (four days later). Further interview revealed the pressure ulcer increased to a Stage II on October 7, 2012, and weekly skin audits had not been completed. The DON confirmed the facility failed to initiate treatment immediately and the Stage II pressure ulcer could have been avoided.<br><br>Resident #10 was admitted to the facility on November 2, 2012, with diagnoses including Malignant Neoplasm of Uterus, Hypertension, Depressive Disorder, and Diabetes. The resident expired at the facility November 28, 2012.<br><br>Medical record review of the Physician's Discharge Orders from the (hospital) inpatient unit dated November 1, 2012, revealed no orders for treatment of the pressure ulcer on the coccyx.<br><br>Medical record review of the facility Physician's Orders dated November 2012, revealed no orders for the treatment of the pressure ulcer on the coccyx.<br><br>Medical record review of the Nursing Assessment dated November 2, 2012, revealed "...coccyx...pressure...1.5 centimeters (cm) (length) 1.5 cm (width) 0.1 cm (depth) (stage) 11cm..."<br><br>Medical record review of the Braden Scale for Predicting Pressure Sore Risk dated November 3, 2012, revealed the resident walks occasionally and was a low risk for development of pressure ulcers.<br><br>Medical record review of the nurse Progress Notes dated November 4, 2012, revealed "...Wound care check. Small denuded area to | N 691 | | |

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| N 691 | Continued From page 127<br>buttocks. Cleansed with wound cleaner dried and protective dressing applied..."<br><br>Medical record review of a Nursing Assessment dated November 6, 2012, revealed the resident was totally dependent with two person physical assist for bed mobility and transfer, the resident did not ambulate, and the resident was at risk for developing pressure ulcers.<br><br>Medical record review of the nurse Progress Notes dated November 10, 2012, revealed "...it was discovered that there was a (reddened) purple non blanchable area with open and bleeding area on the coccyx the back of the upper leg left is (red)...wound nurse from another facility said that the wound was a stage 3 wound...cleaned up the wound...The facility wound care nurse was notified and it was put in...wound care book...to further eval (evaluate) and treat..."<br><br>Medical record review of the Wound Assessment dated November 12, 2012, revealed "...(B) (bilateral) buttocks/sacrum pressure 11 cm (length) 14 cm (width) 0.1 cm (depth) suspected deep tissue injury(SDTI)..."<br><br>Medical record review of a Physician's Order dated November 12, 2012, revealed "...Diffuse scattering of pressure ulcers-new onset (at) both buttocks-stage I, stage II and suspected deep tissue injury. Cleanse entire area (with) NS (normal saline), apply skin prep to intact skin (and) cover (with) protective (dressing) q.o.d. (every other day) Air mattress in use continuously. Reposition q (every) 2 hrs (hours)...skin prep L (left) heel-site of now healed PU-as precaution. "Float heels..." | N 691 | | |

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| N 691 | Continued From page 128<br><br>Medical record review of the Treatment Record dated November 2012, revealed no documentation treatment was provided to the bilateral buttocks and coccyx on November 12 or November 14, 2012.<br><br>Medical record review of the Progress Notes dated November 15, 2012, revealed "...Assessed pressure ulcer at sacral/buttocks area. Slough over 90% of ulcer surface. New orders obtained and written to initiate debridement. New stage 1 PU (pressure ulcer) noted at Right heel..."<br><br>Medical record review of a Physician's Order dated November 15, 2012, revealed "...Cleanse pressure ulcer (at) sacrum/buttocks (with) NS or wound cleanser, pat dry, apply silvadene then cover (with) Adaptic secure (with) protective absorbent (dressing). (change) and assess daily until slough then may decrease to QOD...skin prep Bi-lat (both) heels QD (every day) Float heels..."<br><br>Medical record review of the Treatment Record dated November 2012, revealed no documentation treatment was provided to the pressure ulcer on the sacral/buttocks on November 19, 22, or 24, 2012.<br><br>Medical record review of a Nutritional Risk Assessment dated November 15, 2012, revealed "...Nutritional Intervention Liberalize diet to Mech (mechanical) soft, Regular diet. Send high protein snacks. Monitor and fu (follow up) prn... The Nutirtional Risk Assessment was not completed until thirteen days after the resident was admitted.<br><br>Medical record review revealed no nursing assessment of the wound had been completed | N 691 | | |

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| N 691 | Continued From page 129<br>the week of November 19, 2012.<br><br>Medical record review of Physician's Order dated November 25, 2012, revealed "...Cleanse PU (at) sacrum/buttocks (with) Dakin's solution, pat dry, apply santyl to eschar and /or slough, fill space (with) Dakin's dampened 4 x 4's. Secure with protective/absorbent dressing. Change and assess daily prn (as needed)..."<br><br>Medical record review of a Physician's Order dated November 25, 2012, revealed "...Air mattress (Bariatric)..."<br><br>Interview on January 24, 2013, at 9:30 a.m., with the Director of Nursing (DON), in the conference room, confirmed no orders for treatment of the pressure ulcer were obtained on admission resulting in a delay of treatment of the pressure ulcer and a thirteen day delay in dietary assessments and interventions.<br><br>Interview on January 28, 2013, at 9:45 a.m., with the Registered Nurse (RN) #1, confirmed the pressure ulcer started on the coccyx, diffused to the buttocks, within the 11 cm x 14 cm deep tissure injury was an open area, but no specific measurements of the open area were obtained. Further interview confirmed the Braden Scale assessment was inaccurate, and no assessment of the wound had been completed the week of November 19, 2012. | N 691 | | |
| N 705 | 1200-8-6-.06(4)(cc) Basic Services<br><br>(4) Nursing Services.<br><br>(cc) A registered nurse may make the actual determination and pronouncement of death under the following circumstances: | N 705 | | |

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| N 705 | Continued From page 130<br><br>1. The deceased was a resident of a nursing home;<br><br>2. The death was anticipated, and the attending physician or nursing home medical director has agreed in writing to sign the death certificate. Such agreement by the attending physician or nursing home medical director must be present with the deceased at the place of death;<br><br>3. The nurse is licensed by the state; and,<br><br>4. The nurse is employed by the nursing home in which the deceased resided.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to ensure a Registered Nurse pronounced the death for two residents (#40, and #5) of seventy-nine residents reviewed.<br><br>The findings included:<br><br>Resident #40 was admitted to the facility on October 9, 2012, with diagnoses including Metastatic Prostate Cancer, Asthma, Congestive Heart Failure and Hypertension.<br><br>Medical record review of a nursing note, authored by Licensed Practical Nurse (LPN) #20, dated January 11, 2013, at 5:45 p.m., revealed "Pt (patient) lying back in w/c (wheelchair), resp (respiration) labored. Placed back in bed per 3 staff members. At that time respirations had ceased. Vital signs checked; but unable to be obtained. Pupils not responding to light. Pt not responding to name being called or sternal rub... | N 705 | | |

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| N 705 | Continued From page 131<br>(family member) called facility and stated...would like body to be sent to...Funeral Home..."<br><br>Interview on January 24, 2013, at 12:55 p.m., with LPN #20, at the nursing station, confirmed there was no Registered Nurse in the building at the time of the resident's death to pronounce the resident's death.<br><br>Resident #5 was admitted to the facility on May 31, 2012, with diagnoses including Chronic Pain, Bacteremia, and Acute Myocardial Infarction.<br><br>Medical record review of a Nurse Progress Note Dated January 31, 2013, at 11:30 p.m., revealed "...called to PT (patient) room, pt nonresponsive...body cool to touch...mouth open with no respirations...unable to obtain vital signs...PT was a DNR (do not resuscitate)...call placed to NP (Nurse Practitioner) #4...call returned at 12:30 a.m., and death pounced..."<br><br>Interview with the Corporate Nurse #1 on February 13, 2013, at 10:45 a.m., confirmed the resident had ben pronounce dead by telephone and no Registered Nurse had been at the facility to pronounce death. | N 705 | | |
| N 746 | 1200-8-6-.06(8) Basic Services<br><br>(8) Laboratory Services. The nursing home must maintain or have available, either directly or through a contractual agreement, adequate laboratory services to meet the needs of the residents. The nursing home must ensure that all laboratory services provided to its residents are performed in a facility licensed in accordance with the Tennessee Medical Laboratory Act (TMLA). All technical laboratory staff shall be licensed in | N 746 | | |

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| N 746 | Continued From page 132<br>accordance with the TMLA and shall be qualified by education, training and experience for the type of services rendered.<br><br>This Rule is not met as evidenced by:<br>Based on medical record review, facility policy review, and interview, the facility failed to obtain lab tests as ordered, or in a timely manner, for eleven residents (#35, #36, #26, #17, #43, #38, #19, #34, #10, #5, #20) of seventy-nine residents reviewed. The facility's failure to obtain lab tests as ordered or in a timely manner placed resident #35, #36, #26, #17, #43, #38, #19, #34, #10, #5, and #20, in an environment which was detrimental to their health, safety and welfare.<br><br>The findings included:<br><br>Resident #35 was admitted to the facility on August 31, 2012, with diagnoses including Clostridium Difficile (C-Diff-a contagious bacterial organism which causes diarrhea).<br><br>Medical record review of a Physician's Telephone Order dated September 10, 2012, revealed, "Contact isolation for C-Diff...Repeat stool culture (for C-Diff)...upon completion of Abx (antibiotic) (September 20, 2012). Medical record review revealed no lab result for the repeat stool culture.<br><br>Medical record review revealed a Physician's Telephone Order dated September 28, 2012: "...Vancomycin (antibiotic) 250 mg (milligrams) Q (every) 6 hrs (hours) x (times) 10 days...Dx: (diagnosis) C-Diff Diarrhea...Vanc (Vancomycin) level 10/2/12 (lab test to check for therapeutic blood level of the antibiotic). Medical record review revealed no lab result for the Vancomycin | N 746 | | |

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| N 746 | Continued From page 133<br>level.<br><br>Medical record review of a Physician's Telephone Order dated January 10, 2013, revealed, "...Obtain UA (urinalysis) and C&S (culture and sensitivity) for increased confusion, burning (on urination), freq (frequency)..." Medical record review revealed no lab result for the UA and C&S.<br><br>Interview with the Assistant Director of Nursing (ADON) on January 23, 2013, at 4:15 p.m., in the conference room, confirmed the facility failed to obtain the stool culture as ordered on September 20, 2012, failed to obtain the Vancomycin level as ordered on October 2, 2012, and failed to obtain the UA and C&S as ordered on January 10, 2013. The ADON stated the laboratory verified the labs had not been completed as ordered for Resident #35.<br><br>Resident #36 was admitted to the facility on August 12, 2012, and readmitted on September 7, 2012, with diagnosis including Aortic Valve Disorder. Medical record review of a Physician Progress Note dated November 28, 2012, revealed "...Repeat INR (lab test to measure the blood clotting time) in one week (due on December 5, 2012). Medical record review revealed no INR was completed until December 27, 2012 (twenty-two days later).<br><br>Interview with the Director of Nursing (DON) on January 30, 2013, at 1:20 p.m., in the DON office confirmed the facility failed to obtain the INR lab test as ordered.<br><br>Resident #26 was admitted to the facility on April 13, 2012, with diagnoses including Debility, Hypoglycemia, Chronic Pain, and Alcoholism. | N 746 | | |

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| N 746 | Continued From page 134<br><br>Medical record review of a Nurse Practitioner's (NP) order dated November 5, 2012, revealed laboratory tests were ordered: CBC (complete blood count), CMP (comprehensive metabolic panel), UA (Urinalysis) and C&S (Culture and Sensitivity). Medical record review revealed no lab results for the tests.<br><br>Medical record review of a NP's note dated November 9, 2012, revealed, "...Staff request visit today due to increase fatigue and confusion...Labs ordered on 11/05/12 however they were never collected...we will ensure staff to collect UA, C&S, CBC, CMP...to find cause of change in mental status..."<br><br>Medical record review of the NP's order dated November 9, 2012, revealed, "please draw labs ordered 11/5..."<br><br>Medical record review revealed no UA and C&S was obtained from November 9, 2012, until December 7, 2012 (28 days later).<br><br>Interview with the DON on February 5, 2013, at 5:00 p.m., in the conference room, confirmed the facility failed to obtain laboratory tests as ordered.<br><br>Resident #17 was admitted to the facility on August 5, 2009, with diagnoses including Diabetes Mellitus and End Stage Renal Disease.<br><br>Medical record review of a Physician's Telephone Order dated January 8, 2013, revealed, "...Stool culture for C-Diff..." Medical record review on January 23, 2012, revealed no laboratory results for the ordered test.<br><br>Interview on January 23, 2013, at 2:48 p.m., at the 400 hall nurse's desk, with Licensed Practical | N 746 | | |

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| N 746 | Continued From page 135<br>Nurse (LPN #23) confirmed the stool culture had not been completed.<br><br>Resident #43 was admitted to the facility on December 24, 2012, with diagnoses including Dementia, Compression Fracture, Diabetes Type 2 and Hypothyroidism.<br><br>Medical record review of a Physician's Telephone Order dated January 2, 2013, revealed, "...UA, C&S..." Continued medical record review revealed the UA and C&S was not completed until January 8, 2013 (six days after the test was ordered). Medical record review of the Laboratory test results revealed the resident had a urinary tract infection (UTI).<br><br>Interview with the NP on January 30, 2013, at 9:58 a.m., at the 400 hall nurse's desk, confirmed failure to obtain the UA and C&S for six days after it was ordered resulted in a delay in treating the resident for the UTI.<br><br>Resident #38 was admitted to the facility on December 21, 2012, with diagnoses including Severe Sepsis, Urinary Tract Infection, Atrial Fibrillation, and Senile Dementia.<br><br>Medical record review of a Physician's Telephone Order dated December 27, 2012, revealed, "...UA and C&S..." Medical record review revealed the UA and C&S was not obtained until December 31, 2012 (four days later).<br><br>Interview with the DON on February 8, 2013, at 10:53 a.m., in the conference room, confirmed the facility failed to ensure the UA and C&S was obtained timely when ordered.<br><br>Resident #19 was admitted to the facility on | N 746 | | |

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| N 746 | Continued From page 136<br><br>November 9, 2012, with diagnoses including Cerebrovascular Disease, Guillain-Barre syndrome, Coronary Artery Disease, Hypertension, Dementia, Osteoporosis, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Acute on Chronic Renal Failure.<br><br>Medical record review of a Physician/NP's order dated November 13, 2012, revealed a UA with C&S was to be performed.<br><br>Medical record review of a laboratory report, obtained by the facility on November 14, 2012, with results received by the facility on November 18, 2012, revealed "...urine culture results...mixed gram positive bacteria identification and sensitivities not routinely performed..." Continued review of the laboratory report revealed an undated order to repeat the UA with C&S secondary to contaminated specimen.<br><br>Medical record review revealed no documentation of a repeat UA with C&S until November 23, 2012.<br><br>Medical record review of a Physician/NP's order dated January 2, 2013, revealed orders to obtain a UA with a C&S.<br><br>Medical record review of a positive urine C&S report obtained on January 4, 2013, and reported to the facility on January 7, 2013, revealed the causative organism was Morganella Morgannii.<br><br>Interview on January 23, 2013, at 7:30 a.m., with the DON, in the DON's office, confirmed there was a delay in completing the repeat UA with C&S on the specimen received by the facility on November 18, 2012, until November 23, 2012, (5 days later). Continued interview with | N 746 | | |

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| N 746 | Continued From page 137<br>the DON confirmed there was a two day delay in collecting the UA with C&S ordered on January 2, 2013.<br><br>Resident #34 was admitted to the facility on March 22, 2012, with diagnoses including Osteoporosis, Diabetes and Hypothyroidism.<br><br>Medical record review of a Physician's Order dated October 25, 2012, revealed,"...UA, C&S...Altered Mental Status..." Medical record review revealed no laboratory results for the ordered tests on October 25, 2012.<br><br>Medical record review of a Physician's Order dated October 29, 2012, revealed, "...UA C&S for AMS (altered mental status). Medical record review of Urinalysis and Culture laboratory reports dated October 29, 2012, revealed the resident had a UTI, "...organism 1 Klebsiella Pneumoniae...colony count > (greater than) 100,000...sensitive to gentamycin (antibiotic)..."<br><br>Interview with the ADON on January 30, 2013, at 8:45 a.m., in the conference room, confirmed the UA, C&S had not been obtained as ordered on October 25, 2012.<br><br>Resident #10 was admitted to the facility on November 2, 2012, with diagnoses including Malignant Neoplasm of the Uterus, Depressive Disorder and Diabetes. Medical record review revealed the resident expired at the facility on November 28, 2012.<br><br>Medical record review of the Physician's Orders dated November 2, 2012, revealed, "...CBC, BMP (basic metabolic panel)...Every 180 days...order date 11/2/2012 start date 11/2/12..." Medical record review revealed no laboratory results for | N 746 | | |

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| N 746 | Continued From page 138<br>the ordered laboratory tests.<br><br>Interview with the ADON on January 28, 2013, at 1:30 p.m., in the conference room, confirmed the facility failed to obtain the laboratory tests on November 2, 2012, as ordered by the physician.<br><br>Resident #5 was admitted on May 31, 2012, with diagnoses including Urinary Tract Infection, Bacteremia, Chronic Pain, and Pressure Ulcer.<br><br>Medical record review of a Physician's Telephone Order dated October 25, 2012, revealed "...CBC...10/27..."<br><br>Medical record review revealed the CBC ordered by the Physician on October 27, 2012, had not been obtained.<br><br>Medical record review of a Physician's Telephone order dated October 31, 2012, revealed " ...UA C&S 11/1/12..."<br><br>Medical record review revealed the UA C&S ordered by the physician had not been obtained.<br><br>Interview with the ADON on January 21, 2013, at 10:35 a.m., in the ADON Office, confirmed the UA C&S had not been obtained as ordered by the physician.<br><br>Resident #20 was admitted to the facility on May 10, 2012, and readmitted on December 14, 2012, with diagnoses including Altered Mental Status, Status Post Cerebral Vascular Disease, and Deep Vein Thrombus right upper extremity.<br><br>Medical record review of an Order Summary Report dated December 1-31, 2012, revealed "...UA C&S one time only for UTI...order date | N 746 | | |

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| N 746 | Continued From page 139<br>12/09/2012..."<br><br>Medical record review revealed no UA C&S had been completed for resident #20 on December 9, 2012.<br><br>Interview with LPN #6 on February 14, 2013, confirmed no UA C&S had been completed as ordered by the Physician.<br><br>Review of facility policy, Laboratory Procedures/Other Diagnostic Services, revealed " ...It is the policy of this facility to provide laboratory and diagnostic studies for all residents in compliance with Federal and State requirements. All tests will be completed as ordered, results obtained and reported to the attending physician or Medical Director..."<br><br>Interview with the DON on February 7, 2013, at 1:45 p.m., revealed the facility switched to another laboratory provider effective January 1, 2013. Continued interview revealed all staff were not in-serviced on the changes to ordering and processing laboratory requests and who is responsible to ensure laboratory findings are communicated to the Physician or Medical Director. Interview revealed that a new component of entering information into the laboratory provider's web site needed to be initiated. Interview revealed that the Medical Assistants (Unit clerks)are responsible to check the front fax machine for labs once they are processed and sent back to the facility to review. Interview revealed the Medical Assistants are responsible to make a copy and give to the Unit Managers, who are responsible to check the front fax when the Medical Assistants are absent.<br><br>Interview with LPN #8 on February 13, 2013, at | N 746 | | |

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| N 746 | Continued From page 140<br><br>8:25 a.m., in the facility conference room, revealed the LPN was not in-serviced on the new laboratory system. Continued interview revealed "...There has always been a problem with labs, not...(old lab) or new lab the problem was with the computer..." Interview revealed the new laboratory system must be accessed by going to the laboratory provider's web site.<br><br>Interview with LPN #15 on February 13, 2013, at 8:34 a.m., in the facility conference room, revealed the LPN had not been in-serviced on the laboratory system "...no one showed me how to do it (access laboratory system)."<br><br>Interview with LPN #10 on February 13, 2013, at 9:03 a.m., in the facility conference room, revealed "...we never got any training on new system (new lab system started January 1, 2013) we did not know what to do to get new orders done...next time came to work they (staff) said we have a web site and we do it that way (put in laboratory requisitions) that way..."<br><br>Interview with LPN #14, on February 14, 2013, at 7:10 a.m., at the 400 hall nurse's desk, revealed the LPN was not in-serviced on the facility laboratory procedure until just last week.<br><br>Telephone interview with the facility Pharmacy Consultant #2 on February 13, 2013, at 3:45 p.m., revealed when Pharmacist #2 first reviewed the facility in October did not find any labs to review "not even one." Continued interview with Pharmacist #2 revealed "In all my years I never saw anything like it, I didn't know where to start."<br><br>Telephone interview with the Laboratory Manager (of the current contracted lab), on February 14, 2013, at 8:42 a.m., revealed the facility had | N 746 | | |

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| N 746 | Continued From page 141<br><br>concerns with laboratory services in the past. Continued interview revealed the laboratory service was in effect for January 1, 2013, and the Laboratory Manager had in-serviced eight people in the Administrator's office on January 2, 2013. Further interview revealed two of the eight people where the facility Administrator and DON but no documentation of the in-service was completed.<br><br>Telephone interview with RN #4 (the Staff Development) on February 14, 2013, at 9:15 a.m., revealed it was RN #4's responsibility to educate the staff on laboratory requests in the computer system. Continued interview confirmed there was no skill checks for competency on entering requested laboratory studies.<br><br>Interview with the DON on February 14, 2013, at 9:40 a.m., in the DON's office, revealed there was no documentation of any in-servicing on the new lab system. Continued interview confirmed they (the Charge Nurses) did not receive any education on the new system.<br><br>Interview with the Corporate Director of Operations on February 14, 2013, at 10:55 a.m., in the facility admission office, revealed was aware of issues of obtaining laboratory studies as ordered and the Vice President of Clinical Services would be the person responsible for the issues or concerns with the laboratory services (Vice President of Clinical Services was unavailable for interview).<br><br>Interview with the DON on February 7, 2013, at 1:45 p.m., in the DON office, revealed when an order is received it is the responsibility of who (Nurse) takes the order to make sure it is put in the computer system, Night Shift Nurse's are then responsible to print off the report and place in a | N 746 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| N 746 | Continued From page 142<br>laboratory book kept at each nurse's station, Unit Managers are to check the laboratory book daily.<br><br>Interview with RN #3 (unit manager) on February 7, 2013, at 6:30 p.m., at the 300 hall nurse's desk, revealed the RN was not instructed to check laboratory books. | N 746 | | |